healthteam advantage℠

2026

Provider Manual

HealthTeam Advantage Plan I (PPO) H9808-004
HealthTeam Advantage Plan II (PPO) H9808-005
HealthTeam Advantage Eagle Plan (PPO) H9808-009
HealthTeam Advantage Vitality Plan (PPO) H9808-010
HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP) H2624-001

Contents

Welcome to HealthTeam Advantage

Dear Provider,

On behalf of HealthTeam Advantage, thank you for being a part of our network of physicians and providers! We are looking forward to a great year.

We hope this 2026 Provider Manual will make it easier to find the information you need to provide service to your HealthTeam Advantage patients.

Please spend some time reviewing this manual, which is meant to supplement your HealthTeam Advantage network services agreement. Nothing in this manual is intended to alter the terms and conditions of your HealthTeam Advantage network participation agreement.

From time to time, we may revise the terms of this Provider Manual. You will be notified of any such changes, and a current Provider Manual will be available on our website at www.htanc.com. If you are contracted through a medical group or an IPA participation agreement, the medical group or IPA will notify you of changes to this Provider Manual.

If you have any questions, please contact our Provider Concierge department at 844-806-8217, option 5. Feel free to share any specific suggestions for making the Provider Manual a more useful tool.

Thank you for your continued support of HealthTeam Advantage. We look forward to hearing from you.

Sincerely,

Bethany Carter
Director, Provider Services & Network Development

HealthTeam Advantage Contact Information

HealthTeam Advantage Hours of Operation	October 1 – March 31, 8AM - 8PM EST, 7 days a week; April 1 – September 30, 8AM - 8PM EST, Monday - Friday		
Phone for PPO and HMO	**888-965-1965 (TTY 711)**		
Fax	800-820-0774		
Website	www.htanc.com		
Address	HealthTeam Advantage 300 E. Wendover Ave., Ste. 121 Greensboro, NC 27401		
Utilization Management			
Phone	**844-806-8217 option 3 (Monday to Friday 8AM – 5PM)**		
After Hours Phone	336-207-2095		
Fax	844-873-3163		
Provider Portal	https://acuityconnect.conehealth.com		
Care Management			
Phone	**844-806-8217 option 6 (Monday to Friday 8AM – 5PM)**		
After Hours Phone	877-229-8614 (24-hour nurse line)		
Fax	844-873-3163		
Email	caremanagement@htanc.com		
Provider Benefits & Eligibility Verification			
Phone	**844-806-8217 option 1**		
Provider Portal	https://htaprd-provider.nirvanahealth.com		
Payer ID	**88250**		
Email	providerbenefitseligibility@htanc.com		
Provider Concierge			
Phone	**844-806-8217 option 5**		
Email	providerconcierge@htanc.com		
Claims			
Phone	**844-806-8217 option 2**		
Payer ID	**88250**		
Provider Portal	https://htaprd-provider.nirvanahealth.com		
Mailing Address	HealthTeam Advantage Claims Department PO Box 1264 Westborough, MA 01581		
Email	htaclaims@htanc.com		
Zelis			
Phone (Enrollment)	**855-496-1571**		
Phone (Support)	**844-292-4066**		
Pharmacy Services (Nirvana/RxAdvance)			
Phone (Pharmacy Help Desk)	**PPO:** 800-237-1992 (TTY 711) **HMO:** 800-459-0984 (TTY 711)		
Phone (Coverage Determinations/Appeals)	**PPO**: 800-237-1992 (TTY 711) **HMO:** 800-459-0984 (TTY 711)		
Fax (Coverage Determinations/Appeals)	**Part D Coverage Determinations:** 866-871-8565 **Part D Appeals**: 866-836-8043		
Cover My Meds	www.covermymeds.com		
Website (Formulary and Medication lookup):	https://healthteamadvantage.com/2026-pharmacy-and-prescription-drugs/2026-medication-look-up/		
Routine Supplemental Benefit Providers	**Dental: Dominion**	**Vision: VSP**	**Hearing: TruHearing**
Phone	**833-208-3848**	**800-615-1883**	**866-202-2271**
Compliance, Ethics, Fraud, Waste and Abuse (FWA)			
Phone	**855-741-4518**		
Website	www.hta.ethicspoint.com		
Medicare (CMS) Contact Information			
Phone	**800-MEDICARE or 800-633-4227** (TTY 877-486-2048)		
Website	www.medicare.gov		

Unless otherwise specified in your contract with HealthTeam Advantage**,** the information contained in this document will apply. We reserve the right to make changes to this manual as needed to remain compliant with the Centers for Medicare & Medicaid Services (CMS) guidelines. The most current version of our Provider Manual is available on our website, www.htanc.com.

Product Lines

Care N' Care Insurance Company of North Carolina, Inc., dba HealthTeam Advantage (HTA), is a Medicare Advantage Organization (MAO) locally based in Greensboro, North Carolina that offers North Carolina residents affordable, flexible health coverage through a variety of Medicare Advantage (MA) plans.

Our current portfolio includes four PPO plans (three PPO plans with outpatient prescription drug (Part D) coverage (MAPD) plans – Plan I, Plan II, Vitality Plan, and one PPO MA-only plan with no outpatient prescription drug (Part D) coverage – Eagle Plan).

The following service area applies to the respective PPO plans:
Plan I (PPO) and Plan II (PPO): Alamance, Caswell, Davidson, Davie, Forsyth, Guilford, Montgomery, Orange, Randolph, Rockingham, Stokes, and Yadkin counties.

Eagle Plan (PPO) and Vitality Plan (PPO): Alamance, Alexander, Alleghany, Anson, Bladen, Brunswick, Cabarrus, Caswell, Chatham, Columbus, Davidson, Davie, Durham, Forsyth, Gaston, Guilford, Iredell, Lincoln, Mecklenburg, Montgomery, New Hanover, Orange, Pender, Person, Randolph, Richmond, Rockingham, Rowan, Scotland, Stokes, Union, Wilkes and Yadkin counties.

All PPO plans offer comprehensive medical benefits with the ability for members to also seek services out-of-network, along with an array of supplemental ("extra") benefits, including, but not limited to, dental, vision, hearing, and over-the-counter (OTC) items are available on all plans. In-home non-medical support with everyday instrumental activities of daily living (IADLs) and companion services are available through Papa on all PPO plans **except** the Vitality Plan. Our plans also provide physical fitness services through SilverSneakers®. An in-home meal delivery benefit following a qualifying event such as inpatient surgery and discharge from an inpatient hospital or skilled nursing stay is available under all plans **except** the Vitality Plan. Routine non-emergency medical transportation services to or from plan-approved health-related locations, such as inpatient facilities or medical centers and doctors' offices, are available on the Eagle Plan only. PPO Plan documents can be found at www.htanc.com.

HealthTeam Advantage offers a Chronic Special Needs Plan (C-SNP) with prescription drug coverage, HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP). Our Diabetes & Heart Care (HMO C-SNP) plan is designed to meet the specialized needs of Medicare beneficiaries who have certain qualifying medical conditions. This plan is available to qualified Medicare beneficiaries who reside in Alamance, Davidson, Davie, Forsyth, Guilford, Randolph, and Rockingham counties. To be eligible for HealthTeam Advantage's Diabetes & Heart Care (HMO C-SNP) plan, the Medicare beneficiary must have a physician-verified diagnosis for one of the following chronic conditions:

- Diabetes mellitus;
- Chronic Heart Failure (CHF); and/or a
- Cardiovascular disorder (CVD).

Note: *CMS defines Cardiovascular disorder to include cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorder.*

Our Diabetes & Heart Care (HMO C-SNP) plan offers comprehensive medical benefits along with a variety of supplemental benefits to members seeking local care only and not looking for out-of-network benefits. Supplemental benefits under the HMO C-SNP plan include dental, vision, hearing, OTC (including healthy groceries and produce), in-home non-medical support and companion services through Papa, in-home meal delivery benefit following a qualifying inpatient event, and physical fitness services through SilverSneakers®. Routine non-emergency medical transportation (NEMT) to or from plan-approved health-related locations is also available through our vendor partner, SafeRide Health. Plan documents can be found at www.htanc.com.

Product Portfolio

Description of Plans Offered				
Contract-Plan ID	Plan Name	Plan Type	SNP Type	Service Area
H9808-004	HealthTeam Advantage Plan I (PPO)	PPO	N/A	Alamance, Caswell, Davidson, Davie, Forsyth, Guilford, Montgomery, Orange, Randolph, Rockingham, Stokes, Yadkin
H9808-005	HealthTeam Advantage Plan II (PPO)	PPO	N/A	Alamance, Caswell, Davidson, Davie, Forsyth, Guilford, Montgomery, Orange, Randolph, Rockingham, Stokes, Yadkin
H9808-009	HealthTeam Advantage Eagle Plan (PPO)	PPO	N/A	Alamance, Alexander, Alleghany, Anson, Bladen, Brunswick, Cabarrus, Caswell, Chatham, Columbus, Davidson, Davie, Durham, Forsyth, Gaston, Guilford, Iredell, Lincoln, Mecklenburg, Montgomery, New Hanover, Orange, Pender, Person, Randolph, Richmond, Rockingham, Rowan, Scotland, Stokes, Union, Wilkes, Yadkin
H9808-010	HealthTeam Advantage Vitality Plan (PPO)	PPO	N/A	Alamance, Alexander, Alleghany, Anson, Bladen, Brunswick, Cabarrus, Caswell, Chatham, Columbus, Davidson, Davie, Durham, Forsyth, Gaston, Guilford, Iredell, Lincoln, Mecklenburg, Montgomery, New Hanover, Orange, Pender, Person, Randolph, Richmond, Rockingham, Rowan, Scotland, Stokes, Union, Wilkes, Yadkin
H2624-001	HealthTeam Advantage Diabetes & Heart Care (HMO-CSNP)	HMO	Chronic or Disabling Condition (Diabetes and/or Chronic Heart Failure (CHF) and/or a Cardiovascular disorder(CVD)	Alamance, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham

Network Provider Requirements

HealthTeam Advantage must follow certain regulations and requirements as mandated by the Centers for Medicare & Medicaid Services (CMS). CMS considers a contracted provider to be an extension of the Plan. As a contracted network provider, you must also follow certain regulations and requirements. These regulations and requirements are specifically outlined in this manual. Additional regulations and requirements may be described in your provider services agreement with HealthTeam Advantage, whether directly with HealthTeam Advantage or through an IPA or group agreement.

Some of the regulations you will need to be aware of are as follows:

- HealthTeam Advantage will assist providers with enhanced case management for their patients who have complex or serious medical conditions. Case managers will assist providers in assessing conditions and establish and implement a treatment plan.
- Providers may not deny, limit, or apply conditions to the coverage or furnishing of covered services to members enrolled in HealthTeam Advantage based on any condition related to the member's current health status.
- Providers will not discriminate against Members because of their participation as Members, their source of payment, age, race, color, national origin, religion, sex, sexual preference, or disability.
- Providers may not impose any cost-sharing to HealthTeam Advantage members for influenza or pneumococcal vaccines and any other preventative service as mandated by CMS.
- Providers agree to provide all claims encounter data necessary to characterize the context and purpose of each encounter with a HealthTeam Advantage member and a physician, other healthcare professionals, or a healthcare facility.
- Physicians, other healthcare professionals, and facilities agree that all encounter data will be used by HealthTeam Advantage for validating its rates with CMS and that all encounter data and other information submitted to HealthTeam Advantage and ultimately CMS is accurate, complete, and truthful and is based on the physician's, other health care professional's or facility's best knowledge, information and belief.
- Physicians, other healthcare professionals, and facilities acknowledge that misrepresentations about the accuracy of encounter data may result in federal/civil action and/or criminal prosecution.
- Providers agree not to bill HealthTeam Advantage members for covered services (except for applicable deductibles, copayments, or coinsurance) if payment has been denied because the provider has failed to comply with the terms of this manual or the agreement between the provider and HealthTeam Advantage.

- Providers must notify all HealthTeam Advantage members of their financial obligation for non-covered services in writing.
- Physicians, other healthcare professionals and facilities, and entities delegated by them to perform administrative services are considered covered entities under Federal and state privacy laws.
- To the extent required by law, providers and their contracted business associates will keep all medical records containing patient-identifiable information confidential and will not disclose any patient-identifiable information to any third party without the prior written consent of the member.
- Providers shall ensure services provided are documented and incorporated into the member's primary care medical record. Specialty physicians and other providers are required to advise the referring physician when follow-up care is necessary.
- Providers are responsible for the education and training of all individuals working within their medical practice to ensure that procedures outlined in this provider manual are followed correctly. You may contact provider relations to request staff training that may include but is not limited to, billing procedures and administrative policies.
- Physicians, other healthcare professionals, and facilities will make individual medical records available to patients or their legally designated representatives upon request.
- At all reasonable times, physicians, other healthcare professionals, and facilities will provide HealthTeam Advantage, CMS, the Office of Inspector General, and their duly authorized representatives the right of access to its facilities and to its financial and medical records which are directly pertinent to HealthTeam Advantage members to monitor and evaluate cost, performance, compliance measures reporting, quality improvement activities, appropriateness, and timeliness of services provided.
- Physicians, other healthcare professionals, and facilities may not give out or accept applications for enrollment. If an announcement is made to patients of their participation with HealthTeam Advantage, this may only be made one time without mentioning other Medicare health plans with which they participate.
- Provide timely notification to the Provider Concierge Department of any practice changes, provider additions, or terminations.
- Providers are to verify their demographic information on the online Provider Directories every quarter and email network@htanc.com confirming their information.
- Assure access and availability to HealthTeam Advantage members.
- Primary Care Providers must be available to members 24 hours a day, 7 days a week.
- After-hour service providers must have an answering service or answering machine directing members with a phone number on how to reach their PCP or on-call provider.
- Appointments are ***not required*** when:

    - Emergency Services such as life-threatening or serious illness must be provided upon member presentation at the office or facility.
    - Urgent Care requires prompt attention but isn't life-threatening, including specialty urgent care that must be provided within 24 hours of the request.
- Appointments are *required* when:
    - Non-Urgent must be able to schedule an appointment within a week's request.
    - Routine Primary Care is for new medical concerns that are not considered urgent and must be provided within 30 days of requests.
    - Routine Specialty Care referrals must be provided within 30 days of requests.
- Preventative Health Services appointments for wellness check-ups must be provided within 90 days of requests.
    - Initial Outpatient Behavioral Health must be provided within 14 days of the request.

Also, please note the following additional requirements for our Chronic Special Needs Plan:

- The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical Providers and staff to receive basic training about the Special Needs Plans (SNPs) Model of Care.
- The CSNP's Model of Care is the plan for delivering coordinated care and care management to special needs Members.
- SNPs are responsible for conducting their own MOC training, which means you may be asked to complete multiple pieces of training by different health plans.
- CMS requires us to show evidence of the availability of MOC training materials communicated to Providers. Please visit https://htanc.com/providers/required-annual-model-of-care-training-for-csnp-providers/ to access our training materials. **Please note that this training must be completed annually, and a signed attestation is also required.**
- If a member enrolls in the HealthTeam Advantage HMO CSNP plan, a Verification of Chronic Condition (VCC) form must be completed and signed by the member and the member's treating physician.
- The member must have a verified diagnosis of: diabetes mellitus and/or a cardiovascular disorder (CVD) or chronic heart failure (CHF) to qualify for enrollment in the HealthTeam Advantage HMO CSNP plan.
- A completed VCC form must be returned to HealthTeam Advantage within 30 days from the enrollment effective date.
- Note: If a member has one of the diagnoses listed above and a physician does not return the VCC form to HealthTeam Advantage within 30 days after the member's enrollment

effective date, the member will be disenrolled from the plan. Therefore, prompt attention to the VCC form is critical.

HealthTeam Advantage appreciates your dedication to serving the Medicare Advantage population. If you have any questions about the above-listed requirements, please contact your Provider Concierge Representative by email at providerconcierge@htanc.com or by calling 844-806-8217 option 5.

Credentialing

Credentialing is a key part of creating a high-quality network. HealthTeam Advantage is committed to building a network of providers who meet all applicable CMS and state-specific requirements. Providers with a specialty that requires credentialing must have their credentialing application approved by the Credentialing Committee before submitting claims or rendering services to members. PCPs cannot be assigned membership until they have been approved to join our network.

Initial Credentialing

The credentialing process begins in conjunction with contracting and when the group's roster is received. HealthTeam Advantage uses credentialing information from a provider's Council for Affordable Quality Health (CAQH) profile. Providers requiring credentialing must have completed their profile, authorized HealthTeam Advantage to view the information contained therein, and attested to the application's accuracy no more than 180 days before the profile is accessed.

Once we've received a complete credentialing application, HealthTeam Advantage will review it and verify the information contained, and if additional information is needed from the provider a member of our Provider Concierge team will reach out. Failure or delays in responding will delay the credentialing process.

The provider's credentialing application will then be brought before the Credentialing Committee. Providers whose credentialing applications are denied can appeal the Committee's decision. If the Committee needs more information to decide, a member of our Provider Concierge team will reach out to the provider. Additional information about the appeal process is included later in this section.

The Credentialing Committee cannot render decisions on providers who submit incomplete credentialing applications. We will make three outreach attempts over a period of 30 days. Failure to provide the required information will force the credentialing process to cease.

Re-credentialing and Monitoring

Re-credentialing is both a State and CMS requirement. Providers and facilities who have been previously credentialed and are still participating with HealthTeam Advantage are re-

credentialed within no more than 3 years of their last approval date. The re-credentialing process confirms that providers and facilities are still eligible for participation in our network and will identify any information that could affect the provider's ability to render services.

HealthTeam Advantage will use a provider's CAQH profile as their re-credentialing application. In addition, HealthTeam Advantage will review any member grievances filed against the provider. The re-credentialing process grants the same rights outlined in the Initial Credentialing section above.

Each month, HealthTeam Advantage confirms that in-network providers do not appear on the Medicare Opt-out list, the CMS preclusion list, the OIG exclusion list, or the System for Award Management (SAM) exclusion list. We may review the National Practitioner Database (NPDB) reports filed against these providers. HealthTeam Advantage maintains the right to revoke a provider's credentialing status based on information found during the monitoring process. Anyone who is denied re-credentialing will be terminated from the network.

Network Termination

If adverse actions are identified during the re-credentialing process, or as a result of ongoing monitoring activities, HealthTeam Advantage reserves the right to deny a provider's credentialing application or revoke a previously issued approval. In any case, in which the Credentialing Committee has reason to believe that a provider poses an immediate danger to the health or safety of our members, the provider may be suspended or terminated from the network immediately.

A provider who has their application denied or approval revoked by the Credentialing Committee will be notified in writing within 30 days of the decision date. This notification will outline the reason(s) for the revocation and detail the provider's appeal rights.

Per CMS, all providers whose credentialing is denied as a result of deficient care must be reported to applicable authorities. When required, a written notice will be provided to the relevant authorities, including licensing or disciplinary bodies.

Site Visits

Site visits are performed at provider offices and other facilities at the Plan's discretion.
A site visit will evaluate:

- Physical accessibility;
- Physical appearance;
- Adequacy of equipment;
- Medical record-keeping practices and confidentiality requirements including management of Protected Health Information (PHI).

Institutional Provider Certification

HealthTeam Advantage will also determine that each facility and ancillary supplier in our network has completed our Facility Credentialing Application and provides proof of the following:

- Medicare approval;
- Accreditation or a site visit conducted in the last three years;
- Malpractice insurance and;
- Licensure (when required by the state in which the facility is located). Facilities are re-credentialed every three years.

Provider Right to Review and Correct Information

All providers participating in the network have the right to review the file obtained by HealthTeam Advantage to evaluate their credentialing or re-credentialing application. This does not allow a provider to review references, personal recommendations, or other information that is peer-reviewed protected.

Providers have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or re-credentialing process was erroneous or incomplete or should any information gathered as part of the primary or secondary source verification process differ from that submitted by the provider.

Providers do not have the right to review the information that is peer-reviewed protected.

Provider Right to be Informed of Application Status

Contracted providers have the right to request the status of their credentialing application. Providers can send an email to credentialing@htanc.com to obtain.

Provider Right to Appeal Credentialing Decisions

A provider may appeal a credentialing decision made by the Credentialing Committee by submitting a written appeal and any additional information the provider would like to include for consideration. This appeal should be submitted to credentialing@htanc.com within 60 days of the date of the credentialing determination.

Reconsiderations will be reviewed by the Credentialing Committee at the next scheduled meeting and no later than six months from the receipt of the additional documentation.

Provider Concierge & Provider Changes or Updates

Provider Services is the liaison between community providers and the health plan. Under

Provider Services, the Provider Concierge Department offers support, guidance, education, resources, and training, and conducts Provider onboarding and site visits.

Providers are encouraged to contact their assigned Provider Concierge Representative who will be their primary contact for any issues or concerns they may have regarding the HealthTeam Advantage health plan. Issues or concerns can pertain to demographic updates/changes, claims, authorizations, eligibility, contracting, credentialing, etc. Providers can contact their assigned Provider Concierge Representative or Provider Concierge Department at 844-806-8217 option 5 or by emailing providerconcierge@htanc.com.

Provider Additions, Changes, Terminations, and Panel Closure

HealthTeam Advantage adheres to regulatory guidelines when evaluating requests to add, change, or terminate providers and expects providers to provide accurate and timely provider data. Please send all provider adds, changes, and termination requests in writing to network@htanc.com.

Provider (includes Nurse Practitioners and Physician Assistants) changes and updates include, but are not limited to the following:

- Change in practice location.
- Addition of practice location(s).
- Change in practice affiliation.
- Change of address, phone, or fax number.
- Change in hours of operation.
- Retirement or leave of absence exceeding 30 days.
- Leaving the network service area.

Any change to a provider's status should be communicated immediately to the HealthTeam Advantage Network Department. All provider profiles are reviewed for credentialing requirements, including but not limited to the following:

- Provider specialty(ies) and credentials (e.g., MD, DO, MFT, etc.).
- Medical license number and expiration date.
- DEA number and expiration date.
- NPI number.
- Board certification status.
- Professional liability insurance.

The following provider termination timelines are documented in the Provider Agreement between HealthTeam Advantage and the physician group:

- The termination notice must be submitted to credentialing@htanc.com.

- Non-PCP provider adds, change, and termination requests received by the 10th of the current month are processed and will become effective by the 1st of the month.
- Non-PCP provider adds, change, and termination requests received after the 10th of the month are processed and will become effective the 1st of the subsequent month.
- PCP terminations with effective dates of the 1st of the following month are processed as soon as possible, regardless of the submission date. PCP terminations with effective dates after the 1st of the following month are processed within 30 days before the effective date of the termination.

Incomplete requests, or those requiring further attention, will be returned to senders with details regarding the issue(s) found and/or notice of action/additional information needed.

To obtain provider ID numbers, provider organizations are expected to check the Find a Provider section of the HealthTeam Advantage website at www.htanc.com on or after the 1st of the appropriate month according to the timeline established above.

HealthTeam Advantage will notify members of any provider and/or hospital changes, using CMS-approved member letters.

Provider Terminations

Some circumstances occasionally occur that warrant HealthTeam Advantage using the termination provisions in the provider contract. These provisions address immediate terminations for cause, terminations for breach, and terminations at the end of the term of a provider contract. In most cases, Providers are entitled to a review by the Advisory Review Panel, as outlined in the provider contract. HealthTeam Advantage follows the requirements outlined in the provider contract.

In some situations, members are entitled to continue services with a provider that has been terminated, such as in the case of a member who is terminally ill, for example. HealthTeam Advantage will continue to allow a terminated provider to continue providing health services to a member at the member's option for the remainder of their life, for care directly related to the treatment of the terminal illness. Additional situations where a terminated provider may continue to provide services are outlined in the provider contract.

Corporate Information Changes

Corporate information includes, but is not limited to, the organization name and/or dba, organization ownership, tax identification number (TIN), and payee name and address.

Changes to corporate information impact provider reimbursement and require a written letter on letterhead from the physician group that identifies the requested change and is signed by an administrator of the organization. In addition to the letter, a copy of the physician group's Articles of Incorporation, or Service Agreement must also be provided to verify administrators' names. If the request includes a TIN change, a W-9 must be provided. This information can be emailed to network@htanc.com or you may contact your assigned Provider Concierge Representative.

Provider Directory

HealthTeam Advantage provider directory information is available online at the HealthTeam Advantage website at www.htanc.com. If a printed directory is required, please contact our Provider Concierge Department at 844-806-8217 option 5 or email your provider concierge.

HealthTeam Advantage Member Information

Member Eligibility

For an individual to enroll in HealthTeam Advantage Medicare Advantage Plan, the individual must be entitled to Medicare Parts A and B in addition to living within the service area in which the plan is offered. The HealthTeam Advantage service areas for the PPO Plan I and II product lines are Alamance, Caswell, Davidson, Davie, Forsyth, Guilford, Montgomery, Orange, Randolph, Rockingham, Stokes, and Yadkin counties. Service area for PPO Plans Eagle and Vitality are Alamance, Alexander, Alleghany, Anson, Bladen, Brunswick, Cabarrus, Caswell, Chatham, Columbus, Davidson, Davie, Durham, Forsyth, Gaston, Guilford, Iredell, Lincoln, Mecklenburg, Montgomery, New Hanover, Orange, Pender, Person, Randolph, Richmond, Rockingham, Rowan, Scotland, Stokes, Union, Wilkes and Yadkin counties.

The HealthTeam Advantage service areas for the HMO CSNP product line are Alamance, Davidson, Davie, Forsyth, Guilford, Randolph, and Rockingham counties. Medicare Advantage eligible beneficiaries who request enrollment with HealthTeam Advantage will be effective the first day of the month following the date a complete enrollment application is accepted by CMS.

Beneficiaries who are receiving services in a Hospice facility are eligible to enroll with HealthTeam Advantage. Also, enrollment into the HMO CSNP plan requires a provider-signed attestation confirming the member's eligibility based on one or more of the following chronic conditions: diabetes mellitus, chronic heart failure (CHF), and/or cardiovascular disorder (CVD).

Verifying Eligibility

A member's eligibility status can change at any time during a plan year. All providers should consider verifying a member's eligibility upon each visit to their office or facility. There are several options to verify eligibility for HealthTeam Advantage members.

Eligibility Verification Options

Real-time eligibility can be verified using our clearinghouse Payer ID of 88250 for all our products. Providers can also use our secure provider portal 24 hours a day, 7 days a week via https://htaprd-provider.nirvanahealth.com. Lastly, during business hours, providers may call 844-806-8217 option 1. Providers will have access to:

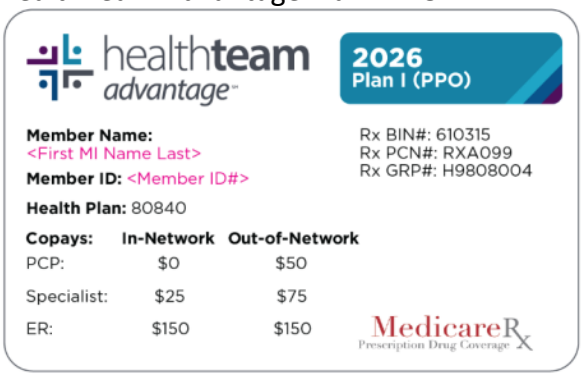
- Member name and ID number.
- Member effective date.
- Member termination date.
- Benefit plan effective date.

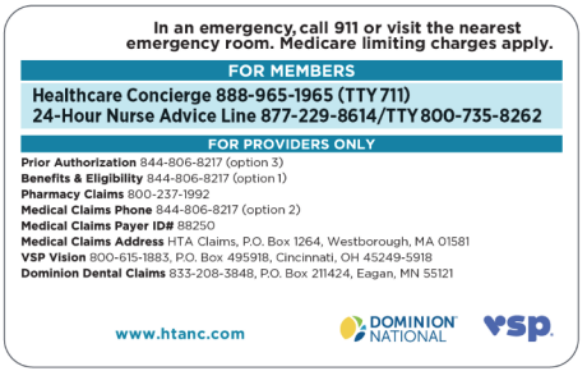
- Benefit information.
- All applicable co-pay or co-insurance amounts

Eligibility ID Cards

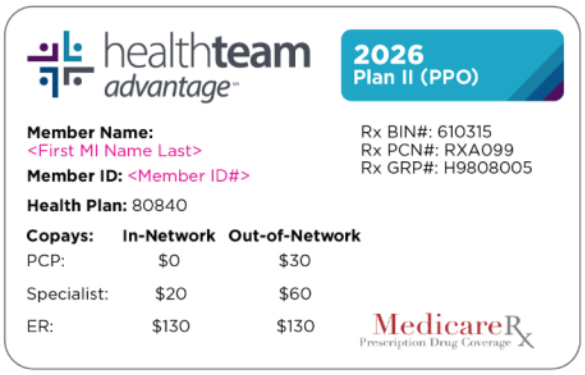
All members enrolled in HealthTeam Advantage's plans receive a member ID card. A sample of the ID cards is below:

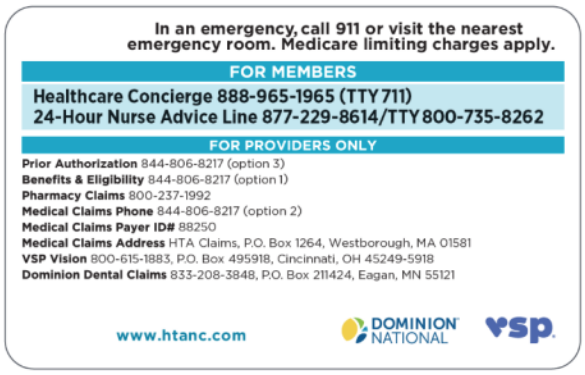
HealthTeam Advantage Plan l PPO:



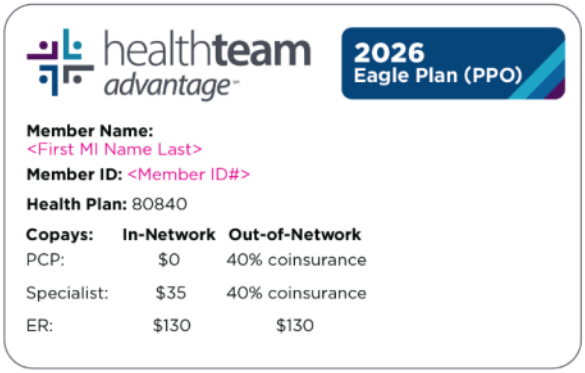


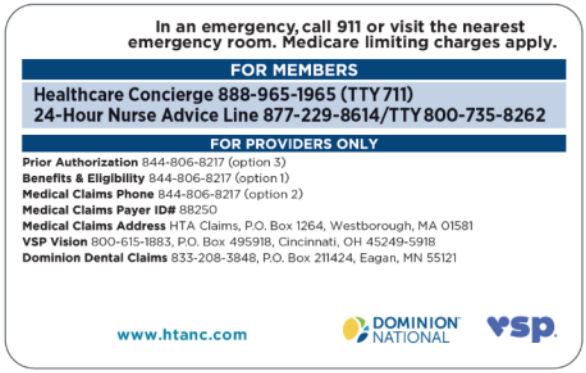
HealthTeam Advantage Plan ll PPO:



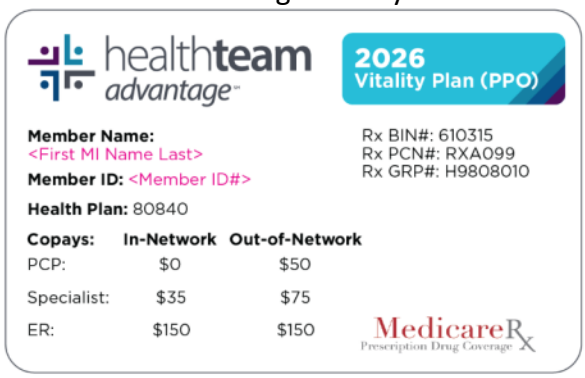


HealthTeam Advantage Eagle PPO:

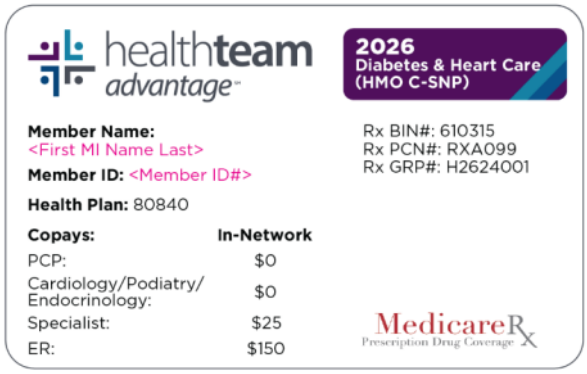




HealthTeam Advantage Vitality PPO:



HealthTeam Advantage Diabetes and Heart Care Plan CSNP HMO:



A new identification (ID) card is automatically sent when:

- A new Medicare Advantage plan member enrolls
- A member changes his or her name
- The member changes Medicare Advantage plans

Members enrolled in HealthTeam Advantage's Medicare Advantage receive a member ID card that contains medical and prescription benefit information. NOTE: The Eagle PPO plan does not offer Part D outpatient prescription drug benefits.

Remember, eligibility data is based upon the best available data to the health plan and may not always be current at the time of the request. Verification of eligibility does not guarantee payment.

Dual Eligible Members

Dually eligible members are those members who qualify for both Medicare and Medicaid. There are different types of eligibility as explained below.

Full Benefit Dual-Eligible

Full-benefit dual-eligible beneficiaries include those individuals who have coverage under both

Medicare and Medicaid. Per CMS guidelines, dual-eligible beneficiaries must enroll in a qualified Medicare prescription drug program to receive prescription medication coverage. Dual-eligible beneficiaries automatically qualify for extra assistance and do not need to apply separately. Beneficiaries who qualify for full dual benefit dual-eligible status may voluntarily choose to enroll in a Medicare Advantage plan, another Medicare health plan that offers prescription coverage, or a stand-alone Prescription Drug Plan (PDP). Beneficiaries who do not enroll in a qualified Medicare Prescription Drug Program are automatically enrolled in one to ensure there is no loss of prescription medication coverage. Full-benefit dual-eligible beneficiaries enrolled in a Medicare Advantage plan are enrolled in a Medicare Prescription Drug Program offered by the same Medicare Advantage organization. The Centers for Medicare and Medicaid Services (CMS) facilitates enrollment.

Other full subsidy-eligible beneficiaries who may receive assistance include:

- Recipients of Medicare and Supplemental Security Income (SSI) only.
- Recipients of State Medicare Savings Programs (MSPs), such as Qualified Medicare Beneficiaries (QMB only), Specified Low-Income Medicare Beneficiaries (SLMB only), or Qualifying Individuals (QI).

MSP recipients receive additional assistance from the beneficiary's state, paying for Medicare premiums and member cost-sharing or copayments. The full subsidy-eligible member listed above automatically qualifies for extra assistance and does not need to apply separately. These beneficiaries generally have slightly higher incomes than full-benefit dual-eligible beneficiaries. Medicaid pays for cost-sharing associated with Medicare, including member premiums.

Other Low-Income Beneficiaries

Beneficiaries with limited income and resources who do not fall into one of the subsidy programs discussed above may still qualify for assistance in paying for Medicare premiums and/or cost-sharing.

These beneficiaries must apply for the Low-Income Subsidy (LIS). Beneficiaries may apply for LIS by contacting the Social Security Administration or the state of North Carolina Medicaid office. You may visit the website at www.ncdhhs.gov.

Generally, the guidelines apply to beneficiaries with incomes less than 150 percent of the federal poverty level and limited assets. The type of income considered is based on the rules of the SSI program. Monthly prescription medication plan premiums, annual deductibles, and prescription medication copayments depend on the beneficiary's annual income and resources, per the United States Health and Human Services (HHS) Poverty Guidelines.

For further information regarding Medicare Savings Programs, you may visit: http://www.cms.hhs.gov/center/PeopleWithMedicareCenter.asp.

Member Rights & Responsibilities

A HealthTeam Advantage member has the right to:

- Choose a Primary Care Physician (PCP) for our PPO product and are required to choose for those enrolled in our HMO Chronic Special Needs Plan (HMO C-SNP).
- A discussion of medically necessary treatment options for his or her condition, regardless of cost or benefit coverage.
- Timely access to Primary Care Providers (PCPs) and referrals to specialists when medically necessary.
- Timely access to all covered services, both clinical and non-clinical.
- Access to emergency services without prior authorization when the member, as a prudent layperson, acts reasonably, believing that an emergent medical condition exists.
- Actively participate in decisions regarding his or her health and treatment options.
- Receive urgently needed services when traveling out of his or her Medical Advantage plan service area, or within his or her Medical Advantage plan service area when unusual or extenuating circumstances prevent the member from obtaining care from his or her PCP, if applicable.
- Be treated with dignity and respect and have his or her right to privacy recognized.
- Exercise these rights regardless of the member's race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care; and to expect these rights to be upheld by HealthTeam Advantage participating providers.
- Confidential treatment of all communications and records about his or her care. The member has the right to access his or her medical records. HealthTeam Advantage and its participating providers must provide members with timely access to their medical records and any information that pertains to them. Except as authorized by state law, written permission from the member or the member's authorized representative must be obtained before medical records can be made available to any person not directly concerned with the member's care or responsible for making payments for the cost of such care.
- Extend these rights to any person who may have a legal responsibility to make decisions on the member's behalf regarding the member's medical care.
- Refuse treatment or leave a medical facility, even against the advice of physicians (providing the member accepts the responsibility and consequences of the decision);
- Be involved in decisions to withhold resuscitative service or forego or withdraw life-sustaining treatment.
- Complete an advance directive, living will, or another directive to his or her medical providers.
- Information about his or her Medicare Advantage plan and covered services.
- Know the names and qualifications of physicians and healthcare professionals involved in the member's medical treatment.

- Receive information about an illness, the course of treatment, and prospects for recovery in terms the member can understand.
- Information regarding how medical treatment decisions are made by the contracting medical group or HealthTeam Advantage, including payment structure.
- Information about his or her medications – what they are, how to take them, and possible side effects.
- Receive as much information about any proposed treatment or procedure as he or she may need to give informed consent or refuse a course of treatment. Except in cases of emergency services, this information shall include a description of the procedure or treatment, the medically significant risks involved, any alternate course of treatment or non-treatment, the risks involved in each, and the name of the person who will carry out the procedure or treatment.
- Reasonable continuity of care and knowing in advance the time and location of an appointment, as well as the physician providing care.
- Be advised if a physician proposes to engage in experimentation affecting the member's care or treatment. The member has the right to refuse to participate in such research projects.
- Be informed of continuing health care requirements following discharge from inpatient or outpatient facilities.
- Examine and receive an explanation of any bills for non-covered services, regardless of payment source.
- General coverage and plan comparison information.
- Utilization of control procedures.
- Statistical data on grievances and appeals.
- The financial condition of HealthTeam Advantage.
- Summary of provider compensation agreements.

A HealthTeam Advantage member has the responsibility for:

- Providing his or her providers the information needed to care for him or her.
- Doing his or her part to improve his or her health condition by following treatment plans, instructions, and care that he or she has agreed on with his or her physician(s);
- Behaving in a manner that supports the care provided to other patients and functioning of the facility.
- Accepting financial responsibility for any copayment or coinsurance associated with covered services received while under the care of a physician or while a patient is at a facility.
- Accepting the financial responsibility for any premiums associated with membership in a HealthTeam Advantage Medicare Advantage plan.
- Accepting financial responsibility for any non-covered service.
- Reviewing information regarding covered services, policies, and procedures as stated in the member's Evidence of Coverage (EOC).
- Asking questions of their PCP or participating provider, and as applicable, the Plan.

HealthTeam Advantage Benefits

This Provider Manual provides participating providers with the necessary information to ensure members enrolled in HealthTeam Advantage's Medicare Advantage plan receive appropriate, timely covered services when needed.

The Summary of Benefits and Evidence of Coverage details the benefits of the HealthTeam Advantage Medicare Advantage plans and all applicable copayments/cost-sharing. Plan documents may be reviewed online at www.htanc.com.

Benefits and policies listed in this provider manual apply to all providers unless specified otherwise in the written Provider Agreement or the member's Evidence of Coverage (EOC).

As a HealthTeam Advantage participating provider, you are required to comply with applicable federal and state laws and all requirements set forth by the Centers for Medicare and Medicaid Services (CMS), which governs the Medicare Program. You are also required to comply with HealthTeam Advantage policies and procedures that may not be listed within this manual. Some services will require prior authorization/ precertification. Please contact your Provider Concierge Representative for further information or with any questions at 844-806-8217 option 5.

Preventive Services

Per Medicare coverage guidelines, the following preventive services are covered as part of the HealthTeam Advantage Medicare Advantage Plans. Some preventive services are covered at 100% and do not have a copay or cost-sharing for the member.

- "Welcome to Medicare" preventive visit, one time only within the first 12 months of Medicare Part B eligibility.
- Abdominal Aortic Aneurysm screening for people with certain risk factors, so long as the member gets an in-network referral for this test because of their "Welcome to Medicare visit".
- Annual wellness visit (AWV) if the member has had Part B for longer than 12 months and cannot take place within 12 months of a "Welcome to Medicare" preventive visit. After the first 12 months, HealthTeam Advantage covers one AWV per calendar year to develop or update a personalized prevention plan based on a member's current health and risk factors.
- HealthTeam Advantage also covers a comprehensive routine physical/preventative medicine exam once per calendar year.
- Annual glaucoma screening once per year, for Medicare beneficiaries who are at high risk, have a family history of the disease, or have diabetes, African Americans who are 50 and older, and Hispanic Americans who are 65 or older.
- A baseline mammogram for female Medicare beneficiaries ages 35-39. One screening

mammogram every twelve months for female Medicare beneficiaries aged 40 and older, and a clinical breast exam once every 24 months.

- Medical nutrition therapy by registered dietitians or other qualified nutrition professionals for Medicare beneficiaries diagnosed with diabetes or chronic renal (kidney) disease (but not on dialysis) and for post-transplant patients.
- Bone mass measurements are covered for those at risk of losing bone mass or at risk of osteoporosis once every 24 months. Medicare covers procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.
- Prostate cancer screening exams for male Medicare beneficiaries aged 50 and older once every 12 months. These exams include a digital rectal exam and a Prostate Specific Antigen (PSA) test.
- HIV screening once every 12 months for Medicare beneficiaries at increased risk for HIV infection. For women who are pregnant, up to three screening exams during a pregnancy.
- Diabetes self-management provides coverage for diabetes outpatient self-management training to include services furnished in non-hospital-based programs. As the physician managing the member's condition, you must certify that the services are needed under a comprehensive plan of care. Services are covered with no copayment. This also provides coverage for blood glucose monitors and testing strips for all diabetics (already covered for insulin-dependent diabetics); limited to the following manufacturers: Blood Glucose Meter and testing supplies – Accu-Chek and Contour and Continuous Glucose Monitor and supplies – FreeStyle Libre Systems.
- Pap tests and pelvic exams are covered every 24 months with no copayment or deductible. For female Medicare beneficiaries at high risk of cervical or vaginal cancers or female of childbearing age with an abnormal Pap test within the past three years, a Pap test and pelvic exam are covered annually with no copayment or deductible. Human Papillomavirus (HPV) tests (as part of a Pap test) are covered once every five years if female member is age 30-65 without HPV symptoms.
- Colorectal cancer screening for people 45 and older, the following are covered:
    - Screening flexible sigmoidoscopy once every 48 months for high-risk patients.
    - Fecal occult blood test once every 12 months; or
    - Fecal immunochemical test (FIT) every 12 months.
    - Screening flexible sigmoidoscopy once every 10 years (120 months) after a previous screening colonoscopy for members not at high risk.
    - Screening colonoscopy every 24 months for high-risk members.
    - Screening colonoscopy once every 10 years (120 months) for members not at high risk.
    - Screening frequency limitations do not apply to follow-on screening colonoscopies following any positive result from stool-based or blood-based biomarker tests.
    - Blood-based biomarker screening tests. A positive result on a blood-based

biomarker test will lead to a follow-up screening colonoscopy, with no beneficiary cost-sharing.
    - Computed Tomography Colonography (CTC)
- Limited preventive dental services. See our EOC for specific benefits and cost-sharing.
- Depression screening once per year in a primary care setting that can provide follow-up treatment and/or referrals.
- Screening and counseling to reduce alcohol misuse, we cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. For members who screen positive for alcohol misuse, up to 4 brief face-to-face counseling sessions per year (member must be competent and alert during counseling) are provided by a qualified primary care doctor in a primary care setting.
- Opioid treatment program services
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs for pregnant women and certain individuals at increased risk for an STI when the tests are ordered by a primary care provider, once every 12 months. Also cover up to two individual 20 to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs as a preventive service only if provided by a primary care provider and take place in a primary care setting.
- Obesity Screening and therapy to promote sustained weight loss. If a member has a body mass index of 30 or more, this counseling is covered if it is provided in a primary care setting where it is coordinated with a comprehensive care plan.
- For smoking and tobacco use cessation, we cover two counseling quit attempts, each equaling up to four face-to-face visits, within 12 months;

Immunizations

Specified immunizations and adult boosters are covered as described below. Medicare Part B covered immunizations include:

- COVID, Pneumonia, and Influenza Vaccine - Per the federal regulations governing Medicare, members may self-refer for COVID, influenza, and pneumococcal vaccines with no copayments. Participating providers who do not provide vaccines should provide the member with a list of affiliated clinics that can provide these vaccines.
- Hepatitis B if a member is at intermediate or high risk and meets Medicare Part B coverage rules. If the condition falls into one of the categories listed below, the vaccine is covered. No copayment applies if this is the only service provided.
    - End-stage renal disease (ESRD) members.
    - Hemophiliacs receiving Factor VIII or IX concentrates.
    - Mentally handicapped institutionalized residents.
    - Persons living in the same household as Hepatitis B carriers.
    - Homosexual men.
    - IV drug abusers.
    - Staff in institutions for the mentally disabled.

- Healthcare workers who have contact with blood or blood-derived bodily fluids.
- Individuals who have not previously received the completed vaccination series.
- Individuals whose vaccination history is unknown.

Immunizations required for foreign travel are not covered. Immunizations fulfilling occupational-related requirements are not covered.

Medicare Part D covered vaccines are listed in our formulary's List of Covered Drugs and will be processed at the drug tier identified in the formulary. You can review this on our website at https://healthteamadvantage.com/members/2026-plan-documents/.

Best Available Evidence

Best Available Evidence (BAE) policy is used when the low-income subsidy information in CMS systems is not correct. CMS relies on monthly files from the states and Social Security to establish an individual's low-income subsidy deemed eligibility and appropriate cost-sharing level. In certain cases, CMS systems do not reflect a beneficiary's correct low-income subsidy deemed status. This may occur, for example, because a state has been unable to successfully report the beneficiary as Medicaid eligible or is not reporting him/her as institutionalized.

Plans may initially rely on evidence presented at the pharmacy to provide a lower cost-sharing status at point-of-sale but must follow up with additional documentation within a specified period. We recommend that sponsors consider this approach to address urgent situations. The Best Available Evidence process will allow CMS and plan subsidy level records to be synchronized for those beneficiaries for whom Medicaid status has not been updated.

Part D plans must accept any one of the following forms of evidence from beneficiaries or pharmacists to make a change to a beneficiary's low-income status:

- A copy of the member's Medicaid card, which includes the member's name and an eligibility date during the discrepant period;
- A report of contact, including the date a verification call was made to the State Medicaid agency and the name, title, and telephone number of the state staff person who verified the Medicaid status during the discrepant period;
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
- A screen print from the State's Medicaid systems showing that an individual's institutional status is based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period; or
- Other Medical coverage provided by the State showing Medicaid status during the discrepant period.

Also, Part D plans must accept any one of the following forms of evidence from beneficiaries or pharmacists to establish that a beneficiary is institutionalized and qualifies for zero cost-sharing:

- A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
- A screen print from the State's Medicaid systems showing that an individual's institutional status is based on at least a full calendar month's stay for Medicaid payment purposes during the discrepant period.

HealthTeam Advantage Compliance

Compliance Program

HealthTeam Advantage has a strong commitment to compliance, integrity, and ethical values. Additionally, the company understands that participation in federal programs is a tremendous responsibility and is committed to following the best practices and guidance from the United States Sentencing Guidelines and CMS. This is demonstrated by the HealthTeam Advantage compliance program, which includes the following elements:

- Written policies, procedures, and standards of conduct;
- Medicare Coverage Database;
- The designation of a Medicare Compliance Officer or designee and compliance committee;
- Effective training and education;
- Effective lines of communication between the Medicare Compliance Officer or designee, the organization's employees, contractors, subcontractors, agents, and directors;
- Enforcement of standards;
- Provision for internal monitoring and auditing;
- Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives;
- Reporting of violations and potential violations;
- Fraud, Waste, and Abuse.

It is the policy of the company to comply with all applicable federal, state, and local laws and regulations. The company maintains ultimate responsibility for fulfilling the terms and conditions of its contract with CMS and for meeting the Medicare program requirements.

For additional information on HealthTeam Advantage's commitment to compliance, integrity, and ethical values, visit our website.

Fraud, Waste, and Abuse

Eliminating Fraud, Waste, and Abuse (FWA) in the delivery of healthcare is an obligation, responsibility, and legal requirement of all HealthTeam Advantage employees and our contracted providers and their employees. This section provides important requirements and expectations in delivering service to members while minimizing risks to yourself and HealthTeam Advantage.

Medicare Providers and Suppliers Deemed Compliant

Under revised CMS guidance, effective December 28, 2015, first-tier, downstream, and related (FDR) entities that are enrolled in Parts A or B of the Medicare program are "deemed" to have

satisfied Fraud, Waste, and Abuse (FWA) training requirements; however, FDRs are NOT exempt from the general compliance training requirement. That is, if you hold a valid Medicare provider agreement or supplier approval and can bill Medicare directly and receive payment, you are deemed compliant with the FWA training requirement. You are still obligated to complete general compliance training.

As a HealthTeam Advantage contracted provider, if you are not "deemed" compliant as indicated above, you are required to meet CMS FWA and general compliance training requirements.

FDRs have three (3) options for ensuring they have satisfied general compliance and FWA training requirements that must be completed 90 days after initial hire/contracting and annually thereafter:

- FDRs complete the general compliance and/or FWA training modules located on the CMS Medicare Learning Network (MLN) and retain the system-generated certificate of completion as proof of completion;
- FDRs can download and incorporate the content of the CMS standard training modules from the CMS website to include in existing compliance training materials and systems;
- FDRs can incorporate the content of the CMS training modules into written documents for providers (e.g., Provider Guides, Participation Manuals, Business Associate Agreements, etc.).

You must also maintain training records or logs of general compliance and FWA training participants from your organization for 10 years. These logs are subject to HealthTeam Advantage and government audit upon request.

FWA Government Regulations

Deficit Reduction Act: The Deficit Reduction Act (DRA) of 2005 is intended to reduce federal expenditures and, in turn, reduce federal deficits. DRA requirements apply to HealthTeam Advantage as a Medicare Advantage organization and apply to our contracted providers by contracting with HealthTeam Advantage for the provision of Medicare Services.

False Claims Act (FCA): As health care providers furnishing services under government programs, you and HealthTeam Advantage are vulnerable to substantial legal risk under the FCA. The FCA prohibits the submission of false or fraudulent claims to the government. For example:

- Knowingly presenting a false record or statement to get a false claim paid or approved by the government;
- Conspiring to defraud the government by getting a false claim allowed or paid;

- Knowingly retaining any government overpayment. These can now be pursued by the government, even if the initial receipt of the overpayment or the submission that caused the overpayment was not at the time knowingly false;
- Concealing, improperly avoiding, or decreasing an obligation to pay money to the government. Liability attaches regardless of whether the provider ever submitted a false claim to get government money or used a false statement to hide it.

Fraud Enforcement and Recovery Act (FERA): Signed into law in 2009, FERA boosts the federal government's power to investigate and prosecute any financial fraud against the government and expands liability under the FCA. Under Section 4 of FERA, liability may attach whether or not there is intent to defraud the government. Therefore, many types of innocuous overpayments could potentially lead to liability under the FCA.

Office of the Inspector General (OIG): The OIG has targeted Medicare Advantage plans for investigations to ensure compliance with all the rules and regulations that govern managed care organizations. OIG civil and monetary penalties codified in the Social Security Act adopt by reference many of the provisions of Civil Monetary Penalties Law (CMPL). For more information about criminal and civil enforcement actions visit the OIG website at https://oig.hhs.gov.

Anti-Kickback Statute: It is a felony to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services paid in whole or in part by a federal health care program. Remuneration includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or kind.

Physician Self-Referral Prohibition Statue: The "Stark Law" prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement unless an exception applies (for example, bona fide employment, Fair Market Value (FMV) compensation arrangement, etc.)

Health Insurance Portability and Accountability Act (HIPAA): HIPAA established health care fraud as a federal criminal offense and increased the penalties. HIPAA 203(b)(1) (42 C.F.R. §420.405) created the Medicare Rewards and Incentives Program (RI) to encourage reporting of sanctionable activities. RI will pay a reward for information that leads to a minimum recovery of $100 from a party determined by CMS to have committed sanctionable offenses.

Patient Protection and Affordable Care Act and the Health Care & Education Reconciliation Act: Add funding to the Health Care Fraud and Abuse Control Funds and integrity programs to fight FWA. Among the other integrity efforts, the reform laws:
- Create a data repository for CMS to match claims with agencies such as the Social Security Administration and Veterans Affairs to identify FWA;
- Require that overpayments be reported and returned 60 days after they are identified;
- Withhold deferral Medicare matching payments for states that fail to report enrollee encounter data; Require that orders for items or services be prescribed by a Medicare-

enrolled physician or other eligible professional for goods or services on or after July 1, 2010;
- Require physicians to maintain and provide upon request documentation for certification for DME and Home Health services for orders made on or after January 1, 2010;
- Require physicians to have a face-to-face encounter with a patient before prescribing DME or Home Health services for those prescribed after January 1, 2010;
- Increase civil monetary penalties for making false statements to federal health care programs or for delaying inspections ($50,000 for each false record or statement);
- Suspend payment during fraud investigations;
- Allow the U.S. Department of Health & Human Services Secretary to place a temporary moratorium on the enrollment of new providers or suppliers if it is determined that this will prevent or combat FWA.

Balanced Budget Act of 1997: Mandated a risk adjustment payment methodology for what is now the Medicare Advantage program, to increase payment accuracy. Risk adjustment strengthens the Medicare program by ensuring that accurate payments are made to Medicare Advantage organizations based on the health status of their enrolled beneficiaries.

Risk Adjustment Data Validation (RADV): Utilizes coding and documentation audits to ensure HealthTeam Advantage's risk adjustment payment integrity and accuracy. The RADV audit occurs after the final risk adjustment data submission deadline for the Medicare Advantage contract year. Therefore, proper medical records and diagnosis code documentation are key to accurate payment and successful data validation. CMS may apply extrapolation methodologies for RADV audits beginning with payment year 2018.

Penalties

Penalties for violating FWA laws include:
- Denial of payment: You will not be paid for disallowed services provided.
- Monetary penalties for violating the FCA are three times the amount of damages that the government sustained, plus civil penalties between $13,946 and $27,894 per claim. Each separate bill, voucher, or other false payment demand constitutes a separate claim;
- Exclusion: Excluded individuals or entities cannot be paid, directly or indirectly, by the federal health care programs, for any items or services they provide.

Expectations

- Document the patient's medical records properly and accurately. A claim for services must be supported by proper documentation in the medical record.
- Do not falsify or misrepresent information on prescriptions;
- Do not dispense expired or altered prescription drugs;
- Know and abide by all applicable laws and regulations;
- Have appropriate policies and procedures to address FWA in your organization;

- Educate yourself and attend scheduled FWA and compliance training opportunities;
- Provide general compliance, FWA, and HIPAA training to your staff upon hire or contracting within the first 90 days and annually as well as upon discovery of non-compliance;
- Require attendance in training programs as a condition of employment/contracting;
- Provide specialized compliance training at least annually that meets CMS training guidelines for employees that have specific responsibilities in Medicare business areas;
- Protect patient information;
- Retain adequate records of employee training for 10 years;
- Strive for accuracy and excellence in service, coding, and billing:
    - Do not upcode;
    - Do not unbundle services;
    - Provide only medically necessary services;
    - Do not bill for services not rendered;
    - Do not bill for worthless services;
    - Do not submit duplicate billing.
    - Do not submit invalid/terminated CPT/HCPCS/modifiers/diagnosis codes.
    - Provide the most specific diagnosis code(s) at the time of the visit.
    - Capture all chronic conditions on an annual basis.
- Always use your NPI number. Protect your information.
- Durable Medical Equipment, Home Health, Laboratory, and Imaging Providers: Always report the referring provider and their valid NPI number;
- Watch for suspicious activity and red flags;
- Do not retaliate against your employees who report FWA concerns in good faith.
- Screen all employees and downstream entities against federal government exclusion lists, including the Office of Inspector General ("OIG") list of Excluded Individuals and Entities and the General Services Administration ("GSA") Excluded Parties List System. Anyone listed on one or both lists is not eligible to support HealthTeam Advantage's Medicare Advantage and Prescription Drug Plans and must be removed immediately from providing services or support to HealthTeam Advantage, and HealthTeam Advantage must be notified upon such identification.

Reporting FWA Concerns

Report concerns of suspected FWA promptly. Some of the most common coding and billing issues include, but are not limited to:

- Billing for services and/or supplies not received. This includes billing for appointments that the member failed to keep.
- Billing for services at a frequency that indicates the provider is an outlier;
- Offering supplies or performing services that are not medically necessary. This includes genetic testing when not medically necessary for diagnosis and treatment.
- Services or supplies solicited via telemarketing efforts;
- Billing non-covered or non-chargeable services as covered items;
- Billing for services that are performed by another provider;

- Upcoding and/or Unbundling;
- Billing for more units than provided/given;
- Services performed by an unlicensed provider but billed under a licensed provider;
- Alteration of records to get services covered;
- Continuing to bill for rented medical equipment after the capped rental period (or return);
- Incorrect reporting of diagnoses or procedures to maximize payments;
- Altering claim forms, electronic claim records, medical documentation, etc., to obtain a higher payment amount;
- Soliciting, offering, or receiving a kickback, bribe, or rebate, e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment;
- Misrepresentations of dates and descriptions of services furnished or the identity of the beneficiary or the individual who furnished the services.

When in doubt, report it. Reporting potential FWA may be done through the compliance helpline, email, or letter via fax or mail at:

Helpline: 855-741-4518
Website: www.hta.ethicspoint.com
Address: HealthTeam Advantage
Attn: Compliance Department
300 E. Wendover Ave., Ste. 121
Greensboro, NC 27401

Potential or actual FWA may also be reported directly to Medicare or the Office of the Inspector General at:

1-800-MEDICARE (1-800-633-4227)
1-800-HHS-TIPS (1-800-447-8477)

Whistleblower Protection

HealthTeam Advantage policies and procedures include the following protections for good-faith reporters of suspected or actual non-compliance, including FWA:

- Confidentiality
- Anonymity
- Non-retaliation

Monitoring FWA Prevention Practices

As part of the annual delegation oversight audit, all delegated entities will present evidence of up-to-date FWA prevention practices, including but not limited to:

- Updated policies and procedures meeting federal and state requirements;
- Updated staff training logs and sign-in sheets.

Prescription Drug Program (Part D)

A formulary is a list of the drugs covered by HealthTeam Advantage. HealthTeam Advantage will generally cover the drugs listed in our formulary if the drug is medically necessary, the prescription is filled at a network pharmacy, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are selected by our plan with the help of a team of healthcare providers. Both brand-name drugs and generic drugs are included in the formulary. A generic drug is a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Not all Drugs are covered by our plan. Certain medications may have restrictions on their use. Please refer to our formulary for more information. The formulary can be found on our website, https://htanc.com/prescription-drugs/2026-pharmacy-information/.

Formulary Changes

HealthTeam Advantage may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much members will pay when filling a prescription. Examples of formulary changes we may make include:

- Adding or removing drugs from the formulary;
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug;
- Moving a drug to a higher or lower cost-sharing tier;

If HealthTeam Advantage removes drugs from the formulary, adds prior authorizations, quantity limits, and/or step therapy restrictions on a drug, or moves a drug to a higher cost-sharing tier and a member is taking the drug affected by the change, they will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the plan year. However, if a brand-name drug is replaced with a new generic drug or our formulary is changed because of new information on a drug's safety or effectiveness, the member may be affected by this change. HealthTeam Advantage will notify the member of the change at least 60 days before the date that the change becomes effective or provide them with a 60-day supply at the pharmacy. This will allow them to work with their physician to switch to a different drug that HealthTeam Advantage covers or request an exception. If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give a 60-day notice before removing the drug from the formulary. Instead, HealthTeam Advantage will remove the drug immediately and notify members taking the drug about the change as soon as possible.

Non-formulary and Prior Authorization/Exception Requests

For certain prescription drugs and all non-formulary drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs most effectively and help us control drug plan costs. A team of doctors and/or

pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult the formulary for more information about these requirements and limits.

The requirements for coverage or limits on certain drugs are listed as follows:

Non-Formulary Drugs

Sometimes, a physician may determine that a non-formulary drug is necessary to treat a member's medical condition.

HealthTeam Advantage has established a process for the physician to request a non-formulary drug be eligible for coverage. The request for coverage should include documentation of the alternatives that have been tried to treat the medical condition. The member must have tried and failed the formulary alternative(s) or have a contraindication to the formulary alternatives.

The timeframe for Non-Formulary exceptions starts when we receive the supporting statement from the prescriber. If we receive the initial request for coverage from a member, we will complete a minimum of three outreach attempts to the prescriber over 14 days. If no supporting statement has been received, the request will be denied for lack of response.

Prior Authorization

HealthTeam Advantage requires prior authorization (prior approval) for certain drugs. This means that the physician must contact us before writing the prescription. If HealthTeam Advantage does not receive the necessary information to satisfy the prior authorization, we may not cover the drug.

NOTE: The prior authorization information for prescription drugs is located on the HealthTeam Advantage website at https://htanc.com/prescription-drugs/2026-pharmacy-information/2026-list-of-covered-drugs/

The timeframe for Prior Authorizations starts when we receive the initial request for coverage from a member or prescriber. We will complete a minimum of three outreach attempts over 24 hours for an expedited (i.e., urgent) request or 72 hours for a standard request. If no supporting statement has been received, the request will be denied for lack of response.

Quantity Limits

For certain drugs, HealthTeam Advantage limits the amount of the drug that we will cover per prescription or for a defined period.

The timeframe for Quantity Limit exceptions starts when we receive the supporting statement from the prescriber. If we receive the initial request for coverage from a member, we will

complete a minimum of three outreach attempts to the prescriber over 14 days. If no supporting statement has been received, the request will be denied for lack of response.

Step Therapy

In some cases, HealthTeam Advantage requires the member to first try one drug to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, we may require the member's physician to prescribe Drug A first. If Drug A does not work for the member, then we will cover Drug B.

The timeframe for Step-Therapy exceptions starts when we receive the supporting statement from the prescriber. If we receive the initial request for coverage from a member, we will complete a minimum of three outreach attempts to the prescriber over 14 days. If no supporting statement has been received, the request will be denied for lack of response.

Generic Substitution

When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/or provide a member with the generic version, unless their physician has advised us that the member must take the brand-name drug and HealthTeam Advantage has approved this request.

If a physician determines that a member is not able to meet an additional restriction or limit for medical necessity reasons or a non-formulary drug is necessary to treat a member, the physician may request an exception (which is a type of coverage determination).
For information on exceptions related to non-formulary drugs, prior authorization, quantity limits, step therapy, and generic substitution, you may submit a coverage determination request. Information and instructions can be found at https://htanc.com/prescription-drugs/2026-pharmacy-information/2026-part-d-coverage-determinations/.
For additional questions or assistance, please contact the Nirvana/RxAdvance Customer Service Department. For our PPO members: 800-237-1992 (TTY 711) and for our HMO members: 800-459-0984 (TTY 711).

Transition Policy

New members of HealthTeam Advantage may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next.

Physicians should talk to the members to decide if they should switch to a different drug that we cover or request a formulary exception to get coverage for the drug. During the period a physician is talking to the member to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a physician with a current member

affected by a formulary change from one year to the next, the physician should request a formulary exception.

Medication Therapy Management Program

HealthTeam Advantage offers medication management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and physicians. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact members who qualify for these programs. If we contact your patient, we hope they will join so that we can help manage their medications. Remember, the patient will not need to pay anything extra to participate.

If they are selected to join a medication therapy management program, we will send them information about the specific program, including information about how to access the program.

Exclusions

Certain medications or medication categories are excluded from coverage for Medicare Part D members, including:

- Non-prescription medications;
- Medications when used for anorexia, weight loss, or weight gain;
- Medications when used to promote fertility;
- Experimental or investigational medications;
- Medications when used for cosmetic purposes or hair growth;
- Medications when used for the symptomatic relief of cough or colds;
- Medications must be purchased exclusively from the manufacturer as a condition of sale;
- Barbiturates (except when used to treat epilepsy, cancer, or a chronic mental health diagnosis);
- Smoking cessation medications that do not require a prescription;
- Medications that are covered under Medicare Part A or Part B.

Pharmacy Coverage Determination and Appeals

HealthTeam Advantage is responsible for making appropriate coverage determinations and ensuring that covered Part D drugs meet requirements governed and approved by CMS. HealthTeam Advantage has a CMS-approved formulary. Not all medications are covered by the plan. Certain medications may have restrictions on their use. Please refer to our formulary for

more information. The formulary can be found on our website, https://htanc.com/prescription-drugs/2026-pharmacy-information/2026-list-of-covered-drugs/.

Types of Coverage Determinations:

Prior Authorizations: The Plan requires prior authorization for certain drugs before we can cover certain drugs. These could be for patient safety, or to ensure that all provisions in the drug-approved conditions are met.
Step Therapy Requests: In certain cases, the Plan will require that certain drugs be tried before we offer coverage for another drug,
Non-Formulary Exceptions: You can ask the plan to cover a medication that is not on our approved formulary. Certain conditions may be required before the Plan will cover a non-formulary medication.
Quantity Limit Exceptions: For certain drugs, the Plan limits the amount of the drug that the Plan will cover.
Tier Exception Requests: Requests can be made to have a medication covered at a lower copay (cost-sharing) tier. Generally, the Plan will only approve a request for a tiering exception if the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating the condition and/or would cause you to have adverse medical effects.

Coverage Determination Decision Timeframes:

Generally, Medicare mandates certain timeframes for rendering a decision on a request for a coverage determination.

Initial Determinations:

- Standard Requests: 72 Hours
- Expedited Requests: 24 Hours

Providers can request that the Plan expedite a request if it is determined that the patient's health could be jeopardized by waiting 72 hours for a decision.

Timeframes for Prior Authorization requests start when the initial call comes in from a member or prescriber's office. Timeframes for exception requests (i.e. Non-formulary, Step-therapy, Quantity Limits, and Tiering Exceptions) start when the supporting statement is received from the prescriber.

In all cases, whether approved or denied, the Plan will forward our decision to you within the timeframes shown above.

If you do not agree with our decision, you have the right to appeal our decision. Instructions to appeal/request a redetermination of the plan's decision are included with all correspondence for which there was a denial.

Redeterminations:

- Standard Requests: 7 Days
- Expedited Requests: 3 Days

Providers can request that the Plan expedite a request if it is determined that the patient's health could be jeopardized by waiting 7 days for a decision.
Timeframes for Prior Authorization requests start when the initial call comes in from a member or prescriber's office. Timeframes for exception requests (i.e. Non-formulary, Step-therapy, Quantity Limits, and Tiering Exceptions) start when the supporting statement is received from the prescriber.

After a coverage determination or an appeal is submitted, HealthTeam Advantage or the plan's Pharmacy Benefit Manager (PBM), RxAdvance may ask you for additional information to make an appropriate coverage determination. These requests can be made via fax or if urgent via telephone. Please be reminded of the timeframe guidelines mandated by CMS and outlined above as requirements for the plan to decide on your requests. Missing information or not responding to information requests can delay or cause a denial of a coverage determination/redetermination request.

Full pharmacy formulary information and prior authorization/step therapy criteria can be located under the plan document section of our website, https://htanc.com/prescription-drugs/2026-pharmacy-information/2026-list-of-covered-drugs/.

HealthTeam Advantage Covered Services

Medical Services

All medical services provided under the HealthTeam Advantage Medicare Advantage plans are done in accordance with Medicare Guidelines. It is always less costly for members to receive their care from an in-network provider; however, our PPO members may choose an out-of-network provider each time they have a service provided. Our HMO members may not choose an out-of-network provider unless prior authorization is obtained. Please note that due to Medicare Guidelines, HealthTeam Advantage is unable to pay for services from a non-Medicare, out-of-network provider. While the service(s) may be covered, we cannot reimburse a provider who does not participate in the Medicare program.

If you are unsure of the network status of a provider you may be referring to, please consult our provider directory at www.htanc.com or contact our Provider Concierge Representatives or Provider Concierge Department at 844-806-8217 option 5 or via email at providerconcierge@htanc.com.

Organization Determinations and Prior Authorizations

As defined by CMS in Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance defines organization determination as any determination made by a Medicare health plan concerning any of the following:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;
- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services promptly, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee; or
- Medicare Savings Accounts (MSA) only: Decisions regarding whether expenses, paid for with money from the MSA Bank Account or paid for out of pocket, constitute Medicare expenses that count towards the deductible; and, before satisfying the deductible, decisions as to the amount the enrollee had to pay for a service.

Expedited Organization Determinations

As defined by CMS in Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance, an enrollee, or any physician (regardless of whether the physician is affiliated with the Medicare health plan) may request that a Medicare health plan expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received. However, if a case includes both a payment denial and a pre-service denial, the enrollee has the right to request an expedited appeal for the pre-service denial.

An expedited organization determination is a decision to authorize or deny a time-sensitive service that meets the criteria for an expedited review of 72 hours for regular expedited requests and 24 hours for part B drug expedited requests.

Prior Authorizations

Additionally, some of our services require prior authorization. Prior authorization is not a guarantee of payment. Prior authorizations are managed by our Utilization Management (UM) department. Always check the Prior Authorization List before submitting a request for Prior Authorization, as we have greatly reduced the number of procedures that require prior authorization. **Please do not submit requests for prior authorization for services that are not on the Prior Authorization List.**

Below is a list of the Prior Authorization forms available. Please visit the For Provider section of our website, www.htanc.com, to download the most current forms or call 844-806-8217 option 3.

- Prior Authorization List (PAL)
- Prior Authorization Request Form
- Home Health Prior Authorization Request Form
- DME Prior Authorization Request Form
- Acute Inpatient, Skilled Nursing Facility and Long-Term Acute Care (LTACH) and Inpatient Rehabilitation Facility Prior Authorization Request Form
- Non-Emergent Ambulance Transport Request Form
- Additional Information Form

When a provider requests authorization for services, it is important to provide the following information:

- Member demographic information, including the identification number and date of birth;

- Current diagnosis and clinical information, including treatment history, treatment plan, and medications;
- Member's chart and previous imaging study results if applicable.
- For newly enrolled members, please include previously covered codes by the prior health insurance carrier.

After the receipt of all necessary information, prior authorization requests are generally processed within five (5) business days of the receipt of the request by our UM Department. **Note, per CMS guidelines, the turnaround time for standard requests is seven (7) days**. All reasonable efforts will be made to process requests sooner than the set guidelines. Failure to receive prior authorization for these services will result in a denial of payment and the member cannot be billed for the services. The provider may have appropriate appeal rights.

The notification process should be addressed by calling our UM Department at 844-806-8217 option 3 or faxing the appropriate prior authorization form to 844-873-3163.

Urgent prior authorization or precertification requests may be submitted to our UM Department through our provider portal for specific request types, https://acuityconnect.conehealth.com, or via fax using the prior authorization request form 24 hours a day, 7 days a week. After normal business hours, the Utilization Management department can be reached by calling 336-207-2095. HealthTeam Advantage will render a decision within 72 hours after receipt of all necessary information. An enrollee, or any physician (regardless of whether the physician is affiliated with the Medicare Advantage Organization), may request that a Medicare Advantage Organization expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

HealthTeam Advantage members have the right to request prior authorization on their behalf.

Failure to obtain the required authorization may result in a denied claim or a reduction in payment.

When applicable, medical records may be requested by HealthTeam Advantage and/or CMS' Quality Improvement Organization (QIO). Providers are required to submit requested documentation within the timeframe outlined in the request.

Unless an organization determination is requested as expedited, and the clinical justification is provided that applying the standard time for deciding could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, all organization determinations received will be processed as standard, within the allowed 7 calendar day timeframe as determined by CMS.

Laboratory Services

All laboratory services provided under the HealthTeam Advantage Medicare Advantage plans are done so per Medicare coverage guidelines.

HealthTeam Advantage Laboratory services may be obtained from a provider/facility of lab services that are contracted with HealthTeam Advantage or from a non-contracted provider/facility at a higher cost-sharing for the member.

Some HealthTeam Advantage providers may do laboratory work in their offices; however, some services are considered "bundled charges" and are not paid in addition to an office visit fee.

A copayment may be charged for laboratory services received in an office or outpatient hospital setting. For the most current copayment, please refer to the summary of benefits and laboratory services section.

All laboratory claims should contain the Ordering Provider's name and NPI.

HealthTeam Advantage requires prior authorization for genetic testing. For prior authorization requirements for laboratory services, please visit our website at www.htanc.com.

Radiology Services

All radiology services provided under the HealthTeam Advantage Medicare Advantage plans are done so per Medicare coverage guidelines.

HealthTeam Advantage Radiology services may be obtained from a provider/facility of radiology services that is contracted with HealthTeam Advantage or from a non-contracted provider/facility at a higher cost-sharing for the member. For a current listing of radiology service providers, please visit the HealthTeam Advantage website at www.htanc.com. When ordering radiology services, please first check the prior authorization list to determine if the test does indeed require prior authorization. If so, please complete the entire prior authorization form, including all patient information.

Some HealthTeam Advantage providers may perform radiology services in their offices; however, some services are considered "bundled charges" and are not paid in addition to an office visit fee.

All radiology claims should contain the Ordering Provider's name and NPI.

A copayment may be charged for radiology services received in an office or outpatient hospital setting. For the most current copayment, please refer to the summary of benefits, Radiology services section.

Skilled Nursing

Medicare Part A coverage for care and treatment in a Skilled Nursing Facility (SNF) is provided when medically necessary and approved through the prior authorization process by HealthTeam Advantage's UM Department. Skilled nursing care in a sub-acute unit or facility is subject to a 100-day limit per benefit period. Continued stay reviews are completed at a minimum of every 7 days, and if appropriate, the additional length of stay days is approved. Custodial care in a skilled facility or any other facility is not a covered benefit by Medicare under Part A coverage or HealthTeam Advantage.

HealthTeam Advantage waives the 3-day hospitalization requirement for a SNF skilled stay admission. Beneficiaries may be directly admitted into an SNF pending review of medical necessity per CMS Medicare Beneficiary Manual Chapter 8, Extended Care Services.

Skilled nursing and/or skilled rehabilitation services are those services, furnished according to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
- Must be provided directly by or under the general supervision of skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

A copayment per day will be charged for skilled nursing facility care received from a HealthTeam Advantage network provider. For the most current cost share, please refer to the summary of benefits. For a current listing of skilled nursing care providers, visit the HealthTeam Advantage website at www.htanc.com.

Issuance of a NOMNC (Notice of Medicare Non-Coverage) for skilled nursing to HealthTeam Advantage members in a SNF is strictly a function of the health plan.

Home Health

Home Health services must receive prior authorization from HealthTeam Advantage for both initial service requests and ongoing certification requests. Providers requesting Home Health Services for members are to fax the Home Health Authorization Form to our UM department at 844-873-3163. The HealthTeam Advantage Home Health Prior Authorization Form is available on the HealthTeam Advantage website at www.htanc.com. All Home Health services provided under the HealthTeam Advantage Medicare Advantage plan are done so per the Medicare Beneficiary Manual, Chapter 7 Home Health coverage guidelines.

To qualify for the Medicare Home Health benefit, a Medicare beneficiary must meet the following requirements:

- Be confined to the home;
- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- Need skilled nursing care on an intermittent basis, physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

The Utilization Management Department delegates the issuance of the NOMNC (Notice of Medicare Non-Coverage) to home health providers per the amendment to the Participation Agreement with HealthTeam Advantage. According to the terms of the amendment, the Provider will follow the below process when issuing the NOMNC.

- The Provider must use the HealthTeam Advantage (HTA) approved NOMNC.
- The Provider must fax the signed NOMNC to the HTA intake team at 844-873-3163 within two business days of receipt from the Medicare Member.
- The Provider must notify the Utilization Management (UM) department for HTA immediately of all appeals via the on-call phone number at 336-207-2095.
- The Provider agrees to routine audits by HTA's UM department to review supportive documentation used in making its decision to issue the NOMNC.
- The Provider must comply with all Medicare regulations including but not those outlined in Parts C & D Enrollee Grievances, Organization/Coverage
- Determinations, and Appeals Guidance.

If you have any questions, please contact the Utilization Management department at 844-806-8217 option 3.

All Home Health requests and claims should contain the Ordering Provider's name and NPI.

Home Health services provided by a non-contracted provider or facility are covered at a higher cost-sharing. Please refer to the summary of benefits for cost-sharing information. For a current listing of Home Healthcare providers, please visit the HealthTeam Advantage website at www.htanc.com.

Hospice

HealthTeam Advantage members may receive care from any Medicare-certified hospice program. As outlined in section 20.4 in the Medicare Benefit Policy Manual, Chapter 9, Medicare pays the hospice for hospice services and pays for services of the managed care attending physician, who may be a nurse practitioner, (as defined in section 20.1 of this chapter) and services not related to the patient's terminal illness, through the fee-for-service system. (See 42 CFR 417.531 and 417.585.) **Once a managed care enrollee has elected hospice, all his or her Medicare benefits revert to fee-for-service, though the enrollee still remains on**

managed care for any additional benefits provided by his or her managed care plan, such as dental or vision coverage. The Medicare hospice benefit, through fee-for-service Medicare, covers all hospice care from the effective date of election to the date of discharge or revocation. **During the election, fee-for-service Medicare also covers attending physician services and all care unrelated to the terminal illness.** Upon discharge or revocation, fee-for-service Medicare continues to cover the beneficiary through the end of the month when the beneficiary revokes or is discharged from hospice alive. At the start of the month following revocation or discharge, all billing and coverage reverts to the managed care plan (see Pub 100-04, Medicare Claims Processing Manual, chapter 11, §30.4).

HealthTeam Advantage remains responsible for only the member's additional benefits such as vision, dental, hearing, and fitness.

Durable Medical Equipment (DME)

All Durable Medical Equipment (DME) services provided under the HealthTeam Advantage Medicare Advantage plans are done so per Medicare coverage guidelines. Providers requesting DME for members are to fax the DME Prior Authorization Form to our UM department at 844-873-3163, or in limited cases, submit it through our portal, https://acuityconnect.conehealth.com. The DME Prior Authorization Form and the 20262026 Prior Authorization List (PAL) are available on the HealthTeam Advantage website at www.htanc.com. HealthTeam Advantage will not cover DME unless the criteria have been met.

DME is equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally, is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home.

HealthTeam Advantage requires prior authorization and shall cover DME when:

- The equipment meets the definition of DME as listed above;
- The equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his or her malformed body part; and
- The equipment is used in the patient's home.

HealthTeam Advantage contracted providers are required to refer DME to an in-network DME provider.

All DME requests and claims should contain the Ordering Provider's name and NPI.

DME services provided by a non-contracted provider or facility are covered at a higher cost-sharing for members. Please refer to the summary of benefits for cost-sharing information. For a current listing of DME providers, visit the HealthTeam Advantage website at www.htanc.com.

Outpatient Services

Outpatient services include such services as physician office visits, and chiropractic services as well as outpatient hospital services, treatment room, and second opinions. Some of these services will require prior authorization. Please refer to the HealthTeam Advantage website (www.htanc.com) for the most current prior authorization listing of outpatient procedures that require prior authorization.

All outpatient services provided under the HealthTeam Advantage Medicare Advantage plans are done so per Medicare coverage guidelines.

HealthTeam Advantage Outpatient services may be obtained from a provider/facility of outpatient services that are contracted with HealthTeam Advantage or from a non-contracted provider/facility at a higher cost-sharing for PPO members only. For a current listing of outpatient specialty providers/hospital facility providers, please visit the HealthTeam Advantage website at www.htanc.com.

Emergency and Urgent Care

HealthTeam Advantage Medicare Advantage plans cover medical emergencies 24 hours a day, 7 days a week, from any provider in or out of the network. Emergency care can be defined as a condition that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the person's health in serious jeopardy; the danger of serious impairment of the individual's bodily functions; serious dysfunction of any of the individual's bodily organs or parts; in the case of a pregnant woman, serious jeopardy to the health of the fetus; or serious disfigurement.

HealthTeam Advantage does not require prior authorization for emergency services to be covered. However, notification is requested, and in some instances required for claims payment to be made. Please refer to the HealthTeam Advantage website (www.htanc.com) for the most current listing of services that require prior authorization.

Urgently needed care can be defined as non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. If the member is in the plan's service area and network providers are temporarily unavailable or inaccessible, urgent care services will be covered by an out-of-network provider at the lower in-network cost-sharing amount. If the member is outside of the plan's service area and cannot get urgent care from a network provider, the plan will cover such care at the lower in-network cost-sharing amount.

For any emergency or urgently needed care that results in an inpatient stay, the facility must provide notification to the HealthTeam Advantage's UM Department via fax using the prior authorization request form within 48 hours of providing services or as soon as reasonably possible. If a network HealthTeam Advantage facility fails to provide notification within 48

hours or the next business day, the emergency admission will not be covered, and the member cannot be balanced billed.

Inpatient Hospital Services

HealthTeam Advantage Medicare Advantage plans provide coverage for inpatient hospital services in a network acute care facility. Inpatient hospital services require prior authorization/notification, from a provider or facility that a member of HealthTeam Advantage has been admitted or that services have been rendered. When planning an "elective" admission to a network facility, please follow the process outlined in the Utilization Management (UM)/Prior Authorization section of this manual.

When the HealthTeam Advantage's UM Department is notified of hospital admissions, the UM Department verifies eligibility, and the attending physician, and assigns a concurrent reviewer. The UM Department will enter the notification in the system to generate a case number and issue the number. The facility is responsible for obtaining an authorization number by contacting HealthTeam Advantage's UM Department before claim submission.

All elective, urgent, emergent, inpatient, and skilled nursing admissions must be reported to HealthTeam Advantage's UM Department by the next business day unless otherwise stated in the facility contract. To notify HealthTeam Advantage's UM Department you may call 844-806-8217 option 3.

Please have the following information ready to provide:

- Facility name;
- Name of caller reporting admission;
- Phone number of the caller reporting admission;
- Member's full name;
- Member's identification (ID) number;
- Member's date of birth;
- Admission date;
- Admission time;
- Room number (for emergency room notifications, there may not be a room number assigned, as these are potential admissions, and room numbers have not been assigned);
- Admit type (how member arrived at inpatient stay – elective, direct, urgent, or emergent);
- Admitting diagnosis or chief complaint;
- Type of admission (medical, surgical, telemetry, or intensive care);
- Admitting or attending physician;
- Other insurance if available;
- Status of admission (inpatient, skilled nursing, or sub-acute rehabilitation) services may be reviewed after they are provided to determine medical appropriateness. Payment is

not made for services that are inappropriate or not medically necessary.

Services denied for late or non-notification are considered non-reimbursable services and cannot be billed to the member.

Behavioral Health Services

HealthTeam Advantage Medicare Advantage plans provide coverage for inpatient psychiatric care in a network acute care facility. Please follow the process outlined in the Utilization Management (UM)/Prior Authorization section of this manual.

Note that under Medicare guidelines, members qualify for a 190-day Medicare lifetime benefit. If the member has used part of the 190-day Medicare lifetime benefit before enrolling in Medicare Advantage, the member is only entitled to receive coverage for the difference between the number of days already used and the Medicare Advantage authorized benefit.

Psychiatric care in a contracting hospital is subject to the benefits of hospital services. Please refer to the Evidence of Coverage, Chapter 4: Inpatient Services in a Psychiatric Hospital. When the HealthTeam Advantage UM Department is notified of hospital admission, the UM Department verifies eligibility, hospitalist or attending physician assignment, and assigns a concurrent nurse reviewer. The UM Department will enter the notification in the system to generate a case tracking number and issue the number to the caller. The facility is responsible for obtaining the permanent tracking number by contacting the HealthTeam Advantage UM Department before claim submission.

All elective, urgent, and emergent care, inpatient admissions must be reported to HealthTeam Advantage's UM Department within 24 hours or the next business day unless otherwise stated in the facility contract. To notify HealthTeam Advantage's UM Department call 844-806-8217 option 3. Please have the following information ready:

- Facility name;
- Name of caller reporting admission;
- Phone number of caller reporting admission;
- Member's full name;
- Member's identification (ID) number;
- Member's date of birth;
- Admission date;
- Admission time;
- Room number (for emergency room (ER) notifications, there may not be a room number assigned, as these are potential admissions and room numbers have not been assigned);
- Admit type (how member arrived at inpatient stay – elective, direct, urgent, or emergent);
- Admitting diagnosis or chief complaint;

- Type of admission (medical, surgical, telemetry, or intensive care);
- Admitting or attending physician;
- Other insurance, if available;
- Status of admission (inpatient, skilled nursing, or sub-acute rehabilitation).

Services will be reviewed after they are provided to determine medical appropriateness. Payment is not made for services that are inappropriate or not medically necessary. Services denied for late or non-notification are considered non-reimbursable services and cannot be billed to the member.

HealthTeam Advantage does provide outpatient behavioral health service coverage for its members. These services may be obtained by contracted providers/facilities at a set cost-sharing and non-contracted providers/facilities (for PPO members) at a higher cost-sharing. Outpatient behavioral health services include those provided by a specialty provider, individual or group counseling sessions, and visits to a clinical psychologist or licensed clinical social worker. Outpatient behavioral health services also include intensive outpatient (IOP) services and a partial hospitalization program, which is defined as a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Partial hospitalization services require prior authorization.

A HealthTeam Advantage PPO member may self-refer to any of these behavioral health providers and will be charged the applicable cost-sharing for the setting in which care is rendered. For a further explanation of benefits, copayments, and the most current directory of Outpatient Behavioral Health providers, please visit the HealthTeam Advantage website at www.htanc.com.

NOTE: The coverage for mental health counseling does not include relationship or communication issues or behavioral problems not related to an illness or injury, and is subject to payment under the Medicare coverage guidelines.

Plan Directed Care

The Centers for Medicare and Medicaid Services (CMS) defines "plan-directed care" as the health plan and/or its contracted network providers are responsible for ensuring that ordered or referred care is for services covered by the member's plan. If a member believes he or she was either instructed to obtain or authorized to receive a service by a health plan representative (provider), the provider needs to ensure that the service is covered.

Contracted providers have specific responsibilities to the Medicare Advantage membership.

Contracted providers must ensure he or she is providing, supplying, and ordering services that are covered by Medicare. For services that are not covered by Medicare and/or are not a clear exclusion of the member's Evidence of Coverage (EOC), you must obtain an organizational

determination and wait for a determination before services are rendered.

Referring a member to an out-of-network healthcare provider should be done ***only*** when an in-network provider is not available within our service area. When referring a HealthTeam Advantage PPO member outside of our network, prior authorization requirements apply. When referring a HealthTeam Advantage HMO member outside of our network, *all* services require prior authorization. For additional details on our PPO and HMO prior authorization requirements, visit the HealthTeam Advantage website (www.htanc.com).

HealthTeam Advantage providers are required to ensure the non-contracted provider being referred to understands he or she is accepting the patient as plan-directed care, and he or she must provide, supply, and order covered services.

HealthTeam Advantage members will not be held financially responsible for any services ordered by the direction of their primary care provider (PCP) or network specialist if prior authorization or organizational determination guidelines are not followed. As indicated in the CMS Managed Care Manual, Chapter 4, Beneficiary Protections Related to Plan-Directed Care, CMS prohibits holding the member financially responsible in these instances.

HealthTeam Advantage Non-Covered Services

As outlined by CMS, an advanced beneficiary notice of non-coverage (ABN) and any like waivers of notice for non-covered service do not apply to Medicare Advantage Organizations (MAO), therefore they are not appropriate for use by MAO members. MAO members have the right under the terms of the health plan to request an organization determination for non-covered services.

Providers are required to notify HealthTeam Advantage members *before* the delivery of any non-covered service, along with the member's financial responsibility, and to document the notification within the medical record.

Should the determination be decided by the member to proceed with the delivery of a non-covered service, HealthTeam Advantage's Utilization Management (UM) department should be contacted for organization determination. The member or the provider can request the organization's determination.

For further understanding of, and compliance with these requirements, review Chapter 4 of the CMS Medicare Managed Care Manual.

For further information on covered services, please visit our website at www.htanc.com to review the member's Evidence of Coverage (EOC).

Claims

To be reimbursed for services rendered to a HealthTeam Advantage member, providers must submit a clean claim within the timely filing guidelines. All claims for medical services provided under the HealthTeam Advantage Medicare Advantage plans are processed per Medicare Guidelines by our third-party administrator, nirvanaHealth.

HealthTeam Advantage requests that providers file claims electronically for faster service. When submitting claims, please include all required information. HealthTeam Advantage requires that all claims be submitted electronically on a UB-04 for facilities and a current CMS-1500 claim Form for professional services. If you are filing claims manually, you must submit an original UB-04 or CMS-1500 claim form.

Faxed and copied claim forms are not accepted. All providers will receive an Explanation of Payment (EOP) each time a claim is processed that details the payment determinations along with any applicable reason codes.

Timely Filing

When HealthTeam Advantage is the primary payer, providers must make their best effort to submit claims ***within 180 calendar days*** from the date of service, unless the provider's contract specifically states otherwise.

When HealthTeam Advantage is the secondary payer, claims must be submitted within 180 days from the date of the primary EOB decision. A copy of the primary carrier's EOB must be attached to the claim form to process the claim.

If payment is denied due to a provider's failure to comply with timely filing requirements, the claim is treated as a non-reimbursable service and cannot be balance billed to the member. You can dispute a decision of denial for timely filing.

All providers are responsible for reviewing EDI rejection reports from your vendor *and* correcting and resubmitting rejected claims electronically through your vendor.

If you believe you have filed a claim timely, you may request reconsideration for payment in writing along with supporting proof of timely filing which may include:

- EOP from another insurance carrier dated within HealthTeam Advantage's timely filing limits for secondary payments only;
- If the claim was submitted to the incorrect payor the denial of payment letter from the insurance carrier, dated within HealthTeam Advantage's timely filing limits;
- Electronic Data Interchange (EDI) notice including batch number (showing date received versus date of service) that reflects the claim was submitted within HealthTeam Advantage's timely filing limits.

Unacceptable proof of timely filing includes, but is not limited to:

- Screen-print of claim invoices;
- Copies of an original claim;
- Record of billing in an Excel spreadsheet.

Clean Claims

HealthTeam Advantage follows all the CMS claims policies for the Medicare program administration. A copy of the Medicare Claims Manual may be referenced at www.cms.hhs.gov.

A “clean claim” is defined as a claim that contains all necessary information and can be processed as submitted without requiring additional information from the submitting physician, practitioner, or facility.

At least 95% of "clean" Medicare Advantage claims from unaffiliated (non-contracted) providers are to be paid within 30 calendar days of the earliest date received.

Submitted claims that do not meet the clean claims requirements may be pended for additional information or denied if the information submitted is invalid. Providers must submit only the missing information along with a copy of the notification letter, not a corrected claim. Submitting a corrected or second claim only creates duplicates and does not allow the original claim to be processed timely.

If HealthTeam Advantage determines that additional information is necessary to process the claim, the following steps may occur:

- The claim is pended, and on the next business day, a notification letter requesting additional information is mailed to the provider.
- For all professional claims, if the requested information is not received within 45 days from the date the claim has been pended, a second request will be made.
- If the requested information is not received within 60 days from the claim-receipt date of the claim, the claim will be denied.
- For all inpatient and ancillary claims, if the requested information is not received within 60 days from the claim receipt date, the claim will be denied.

If HealthTeam Advantage obtains the requested additional information within 60 days from the receipt of the claim and the information does not support payment or a favorable consideration, the claim will be denied. Providers can access the appropriate dispute process.

Providers should not initiate a new claim after receiving the notification letter requesting additional information. For reference, the notification letter includes the pended claim number that was previously submitted. Once HealthTeam Advantage receives the additional information requested, the original claim is processed.

All requested information must be received at the address indicated in the letter, which is:

HealthTeam Advantage Claims Department
PO Box 1264
Westborough, MA 01581

If payment is denied due to non-compliance with the clean claim requirements, the claim is treated as a non-reimbursable service and cannot be billed to the member; however, the provider can correct their claim and resubmit within the timely filing guidelines.

Claims for HealthTeam Advantage members must comply with the clean claim requirements for fee-for-service Medicare (CFR 422.500).

The following elements *must* be included on the claim:

- Provider identification (ID) number;
- Current Tax Identification Number (TIN);
- Current National Provider Identification Number (NPI);
- Member's name, address, telephone number, gender, and date of birth;
- HealthTeam Advantage member ID number;
- Current CPT code for each procedure performed and any applicable modifiers;
- CMS coding for the place of service and type of service;
- Revenue codes for Departmental revenue, when applicable;
- Diagnosis code number (ICD-10). Indicate appropriate symptoms or diagnoses for tests performed and submit up to four diagnosis codes. Bill to the highest level of specificity;
- ICD-10 procedure and DRG codes for all UB- 04 claims;
- Under Plan Directed Care, the referring provider name and NPI are required;
- Billing provider's name, NPI, TIN, and remit address;
- Date of service;
- Current coordination of benefits (COB) information or other insurance information such as a motor vehicle, workers' compensation, or other third-party liability insurance information;
- If applicable: name and invoice of the chemotherapeutic agent and HCPCS code used for chemotherapy services.

HealthTeam Advantage network providers are required to submit claims for all covered services that are provided to HealthTeam Advantage members.

Additional elements of a claim may be required to process a claim. When additional elements are needed, your claim may be rejected or returned to you for correction and resubmission within timely filing guidelines.

All providers are responsible for reviewing EDI rejection reports from your vendor and correcting and resubmitting rejected claims electronically through your vendor.

“60-Day" Claims

All other Medicare Advantage claims are to be paid or denied within 60 calendar days of the earliest date received.

Electronic Claims Submission

HealthTeam Advantage has contracted with SSIClaimsNet to provide claims clearinghouse services for HealthTeam Advantage electronic claim submission. HealthTeam Advantage providers should file claims for HealthTeam Advantage members electronically whenever possible. No enrollment is required for electronic claim submission.

For clearinghouse support on all electronic transactions, it is advised that providers contact their contracted clearinghouse directly.

Payer Identification (ID) Number for *all* HealthTeam Advantage products (PPO & HMO): 88250

Advantages of submitting claims include:

- Reduction of costs associated with printing/mailing paper claims;
- Data integrity due to clearinghouse edits;
- Faster receipt of claims by HealthTeam Advantage, resulting in reduced processing time and faster payment;
- Confirmation of receipt of claims by the clearinghouse for your records;
- Availability of reports when electronic claims are rejected;
- Ability to track electronic claims, resulting in greater accountability.

EDI Reports

For successful EDI claim submission, participating providers must utilize the electronic reporting made available by their vendor or clearinghouse. There may be several levels of electronic reporting:

- Confirmation/rejection reports from EDI vendor;
- Confirmation/rejection reports from EDI clearinghouse;
- Confirmation/rejection reports from HealthTeam Advantage.

Note: Enrollment is required by SSIClaimsNet to receive your HTA ERA (835). This can be done by opening a ticket with your clearinghouse to enroll you for these transactions with SSIClaimsNet.

Providers are encouraged to contact their vendor/clearinghouse to see how these reports can be accessed/viewed or downloaded. All electronic claims that have been rejected must be corrected and resubmitted. Rejected claims may be resubmitted electronically.

For questions regarding electronic claims submission, contact the HealthTeam Advantage

Provider Services at 844-806-8217 option 2.

Paper Claims Submission

When the electronic filing of claims is not possible, professional paper claims must be submitted on an original red CMS 1500 claim form and must be filled out appropriately to fulfill the requirements necessary in submitting a clean claim. Facility paper claims must be submitted on an original UB-04 claim form and must be filled out appropriately to fulfill the requirements for submitting a clean claim.

Copies of claim forms will not be accepted. Faxed claim forms will not be accepted.

Paper claims can be mailed to:
HealthTeam Advantage Claims Department
PO Box 1264
Westborough, MA 01581

Corrected Claims

Claims must be received by HealthTeam Advantage ***within 180 calendar days*** from the original date of service, even when the submission is a corrected claim, unless otherwise stated in your contract, or payment may be denied. If payment is denied, the claim is treated as a non-reimbursable service and cannot be billed to the member.

Corrected claims must be appropriately marked on top of the claim "Corrected Claim" and submitted to:

HealthTeam Advantage Claims Department
PO Box 1264
Westborough, MA 01581

When resubmitting a corrected claim electronically, you must enter the appropriate claim frequency code "Corrected Claims Process 2010"; Loop 2300; Segment CLM05-3; 7-replacement of prior claim; 8-void/cancel of the prior claim.

Claim Dispute

Contracted providers with HealthTeam Advantage do not have claims appeal rights but do have the right to dispute claims processing and payment.

HTA defines a dispute as a disagreement by a contracted provider regarding the Plan's decision made regarding claims payment, or other related matter, and formally challenges that decision by submitting a written request for reconsideration.

All disputes must be filed ***within 120 days*** of the date of the original Explanation of Payment

(EOP).

Disputes may be made in writing, by supplying all necessary information including, but not limited to:

- Member Name
- Member ID Number
- Claim Number & Date of Service
- A detailed explanation of the dispute
- All supporting documentation such as medical records and provider statement

Disputes should be mailed to:
HealthTeam Advantage Claims Department
PO Box 1264
Westborough, MA 01581

Please note that HealthTeam Advantage does accept disputes via fax for any reason.

Providers may check on the status of their dispute by calling 844-806-8217 option 2. Providers must allow at least 30 days for the review. Additional information on our dispute process can be found on the HealthTeam Advantage website (www.htanc.com).

Post-Service Review

Contracted providers with HealthTeam Advantage have the right to request a post-service review by the plan's Medical Director, in possible conjunction with our Utilization Management Department and/or our Medical Management Committee.
A request for post-service review may be made in writing, by supplying all the necessary information, including, but not limited to:

- Detailed explanation for the request
- Member Name
- Member ID Number
- Claim number & DOS
- All supporting documentation, such as medical records and provider statements

Requests for Post Service Review should be mailed to:

HealthTeam Advantage Claims Department
300 E. Wendover Ave., Ste. 121
Greensboro, NC 27401

Providers may check on the status of their post-service review request by calling 844-806-8217 option 2. Providers must allow at least 30 days for the review.

Electronic Funds Transfer (EFT)

HealthTeam Advantage offers electronic funds transfer (EFT) for claims paid weekly. This is a convenient, cost-effective alternative to receiving your payments through the mail. ***Enrollment is required.*** Failure to enroll in our EFT program will cause all payments to be issued via paper check.

Zelis enrollment is required to receive payments via EFT.
All provider services for Zelis are handled exclusively by Zelis.

If you need assistance, please use the contact information below:

Phone (Enrollment) 855-496-1571 Phone (Support) 844-292-4066

Explanation of Payment (EOP)

HealthTeam Advantage's Explanation of Payment contains all the information about claims submissions, denial or messaging codes, and cash receipts for overpayments, if applicable. The Explanation of Payment should be reviewed when you receive it and reconciled against billing records. The Explanation of Payment includes HealthTeam Advantage member names and dollar amounts paid for all claims processed during a week. Processing claims and adjustments results in one of the following remittance situations:

- Positive remittance - A remittance that totals a positive amount and results in a payment to the provider. The total at the bottom of the Remittance agrees with the check or electronic payment the provider receives.

- Negative remittance - A remittance produced when the adjusted dollars exceed the total amount of payment on the remittance. The total at the bottom of the remittance is negative and does not result in a check or electronic payment to the provider.

EOPs and checks are processed weekly on Thursdays. These will be printed and mailed via USPS on Fridays, or Monday at the latest. If you have not received payment or an Explanation of Payments after 60 days, please visit the provider portal to check on the status of your payment or call the claims department at 844-806-8217 option 2.

Those providers that send their claims electronically via an 837 format, can expect to receive electronic remittance advice (ERA) via an 835 sent back through their clearinghouse and/or Zelis. Providers that receive an 835 response will also receive a paper EOP via the USPS.

A provider has the option to dis-enroll from receiving a paper EOP should they elect to only receive the electronic remittance advice (ERA) via an 835 sent back through their clearinghouse. If you would like to stop receiving paper EOPs, please update your preferences

with Zelis by calling their Provider Services support team at 844-292-4066.

Denials

Claim denials with member liability and provider denials must be issued and mailed within 60 calendar days of the earliest date received.

Refunds

HealthTeam Advantage makes every attempt to identify claim overpayments and issue provider notices for an overpayment refund request within 30 days, but in no case more than 12 months after the date of the original payment.

Should an overpayment occur, HealthTeam Advantage will send a claim overpayment refund request letter with detailed claim information about the payment error and request a return of the overpayment to be returned to the plan within 30 days. If payment is not received within 30 days, a second refund request letter will be issued. The maximum written request for refunds will not exceed three (3) within ninety (90) days.

HealthTeam Advantage reserves the right to pursue additional overpayment recovery efforts if monies are not received. This means if no dispute is filed against the refund request, and the monies are not returned as requested, after 100 days, we will recoup/deduct the amount owed from future payments owed to you through claim activity.

If a provider receives an overpayment refund request letter from HealthTeam Advantage, the provider should follow the instructions promptly, as outlined in the letter for returning the overpayment or disputing the request. If a provider independently identifies an overpayment from HealthTeam Advantage, the following steps should be taken:

Return a check made payable to HealthTeam Advantage to:

Attn: Claim Overpayments
HealthTeam Advantage
PO Box 744676
Atlanta, GA 30374-4676

Include a copy of the Explanation of Payment that accompanied the overpayment to expedite HealthTeam Advantage's adjustment of the provider's account. If the Explanation of Payment is not available, the following information ***must*** be provided:

- HealthTeam Advantage member name and ID number;
- Date of service;
- Payment amount;
- Vendor or provider name and number;

- Provider Tax ID number; and,
- Reason for the overpayment refund.

If you are contacted by a third-party overpayment recovery vendor acting on behalf of HealthTeam Advantage, please follow the overpayment refund instructions provided by the vendor.

Returned Checks

If you believe that you have received a HealthTeam Advantage check in error and have not cashed the check, return the check along with the applicable EOP and a cover letter indicating why the check is being returned to:

Attn: Overpayments
HealthTeam Advantage
PO Box 744676
Atlanta, GA 30374-4676

If you believe that you received a HealthTeam Advantage check or EFT payment in error and that payment was cashed or deposited, please return the payment in full, along with the applicable EOP and cover letter indicating why the funds are being returned to:

Attn: Overpayments
HealthTeam Advantage
PO Box 744676
Atlanta, GA 30374-4676

Coordination of Benefits

Providers should obtain all insurance information from their patients and verify the primary insurance. HealthTeam Advantage will also obtain all insurance information and load any other insurance other than HealthTeam Advantage for the member into the claims system. A member's coordination of benefits can be confirmed using our provider portal at https://htaprd-provider.nirvanahealth.com or by calling 844-806-8217 option 1.

Providers must bill the primary insurance first, before sending the claim to HTA. Upon submission of the claim, please submit proof of payment from the primary insurance company (EOB). HTA will pay the claim as secondary. If the provider submits their claims electronically, they must include the payment information from the other carrier in the appropriate EDI fields on their claim.

Upon review of a member's claims history, HTA may determine that other insurers are responsible for paying the claims before our processing. Should this occur, these claims may be recovered, to the extent of the applicable laws.

In the event a member has other coverage with another carrier, please remember the following:

- Once the primary insurance has been terminated, the Provider is responsible for submitting the initial claim with proof that coverage was terminated.
- If primary insurance has retroactively terminated, the Provider is responsible for submitting the initial claim with proof that payment has been returned to the primary insurance carrier.
- Benefits are coordinated with another insurance carrier as primary and if the payment amount is equal to or exceeds HTA's liability, no additional payment will be made.

Balance Billing

Balance billing is the practice of a contracted, network provider billing a member for the difference between the allowed amount and billed charges for covered services. When participating providers contract with HealthTeam Advantage, they agree to accept HealthTeam Advantage's contracted rate as payment in full. Balance billing members for any covered service is a violation of your Provider Agreement and CMS regulations. Contracted, network providers can only seek reimbursement from HealthTeam Advantage members for copayments, coinsurance, and non-covered services.

Coding

Three major publications, the American Medical Association's Current Procedural Terminology (CPT) code book, the CMS Healthcare Common Procedural Coding System (HCPCS) code book, and the International Classification of Diseases (ICD-10-CM Effective October 1, 2015) represent the basic standard of service code documentation and reference material as required by HealthTeam Advantage. Current ICD-10-CM codes, CPT codes, HCPCS codes, and modifiers reflective of the date of service are required on all HealthTeam Advantage claims. These codes should be used per all applicable federal and state guidelines.

Valid ICD-10-CM diagnosis codes are required on all claims. The first diagnosis on the claim form is reserved for the primary code of each diagnosis to the highest level of specificity (4th or 5th digit when available).

All ICD-10-CM codes are updated yearly on October 1st.
These codes may be updated, deleted, or revised codes. Please remember to include the most specific diagnosis code for the date of service on your claim.

Valid AMA CPT-10 and Level II HCPC procedure codes are required on all claims.
Procedure code modifiers are to be used only when the service meets the definition of the modifier and are to be linked only to procedure codes intended for their use.

All CPT and HCPCS codes are updated yearly on January 1st, with quarterly changes possible. Changes include updates, deletions, or code revisions. Please remember to include the most accurate CPT and HCPCS code for the date of service on your claim.

All providers must bill claims according to CMS guidelines. Some services may be subject to reduction by the multiple procedure reduction rules.

Services and supplies that are covered but considered included in a related service will be denied or bundled into the payment for the related service. HealthTeam Advantage follows the CMS bundled services policy with few exceptions.

HealthTeam Advantage considers other services that are not part of the CMS bundled services policy as always included in a more primary procedure.

HealthTeam Advantage does not require documentation at the time of claim submission. Note that in the event the claim is audited, documentation may be required.

Appeals & Grievances

HealthTeam Advantage follows the requirements as set forth by the Centers for Medicare and Medicaid (CMS) Medicare Advantage Appeals and Grievances. This information can be located in Parts C & D Enrollee Grievances, Organization/CoverageDeterminations, and Appeals Guidance.

HealthTeam Advantage is responsible for processing all Medicare Advantage member grievances and appeals as outlined in the Code of Federal Regulations 42 CFR Part 422 Subpart M and 42 CFR Part 423 Subparts M and U.

HealthTeam Advantage has an internal Appeals and Grievances Department, which is responsible for the processing of all appeals and grievances. This enables HealthTeam Advantage to receive, process, and resolve the issue(s) as expeditiously as the member's health requires and per the CMS timeliness requirements.

What is an Appeal (Reconsideration)?

As defined by CMS Managed Care Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, an appeal is:
As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

When Can A Contracted Provider File an Appeal?

CMS states that Contracted Providers do not have appeal rights. Contracted Providers are not permitted to file appeals on claims. Those must be handled through the Provider Dispute process with the plan's third-party administrator (TPA). See the Claims section of this manual for information on our dispute process. HTA defines a dispute as a disagreement by a contracted provider regarding the Plan's decision made regarding claims payment, or other related matter, and formally challenges that decision by submitting a written request for reconsideration.

Contracted Physicians are only permitted to file appeals on behalf of a member (member must be aware) for pre-service denials and certain types of discontinuation of service denials (SNF, HH, or CORF).

Standard appeal - A standard pre-service appeal request is processed by HealthTeam Advantage within a 30-calendar day time frame, from the date the Plan receives the request. **Expedited appeal -** An expedited appeal request is a time-sensitive service appeal request that is processed by HealthTeam Advantage within a 72-hour time frame, from the date and time the Plan receives the request. For additional information on the criteria for an expedited review, review Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

How to Request an Appeal:

- All appeals must be requested within 65 calendar days of the denial
- Standard and Expedited appeal requests can be requested in writing via fax or postal mail.

Note: For all expedited appeal requests, please clearly state "expedite" on the written request.

Standard requests must be in writing to:

HealthTeam Advantage
Attn: Appeals and Grievances Department
300 E. Wendover Ave., Ste. 121
Greensboro, NC 27401

Fax: 1-800-845-4104

Additionally, expedited requests can be requested verbally through our Healthcare Concierge Department at 888-965 1965 from 8:00 AM – 8:00 PM EST, 7 days a week, between October 1 and March 31, and 8:00 AM – 8:00 PM EST, Monday through Friday between April 1 and September 30th.

Due to the time frames CMS mandates for Medicare Advantage plans to process appeals, plan physicians and providers may receive requests for medical records to assist in the resolution of an appeal.

If all relevant medical records, office notes, etc. are submitted with the appeal request, additional information may not be needed, and this will help ensure a timely decision on the request.

Physicians and providers must forward any requested medical records to the HealthTeam Advantage's Appeals and Grievance Department. When contacted for medical records or other case documentation, the requested information must be furnished within the parameters outlined in the request from HTA Appeals & Grievances. This ensures timeliness with CMS requirements.

What is a Grievance?

As defined in Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, a grievance is An expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include and is distinct from, a dispute of the appeal of an organization determination or coverage determination, or an LEP determination. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility.

An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization's determination or reconsideration, or invoked an extension to an organization's determination or reconsideration time frame.

Member grievances pertain to issues such as:

- Office waiting times;
- Physician demeanor and behavior;
- Office staff demeanor and behavior;
- Adequacy of facilities;
- Quality of care;
- Billing inquiries

If applicable to the grievance, providers may be asked to provide medical records, notes, or a provider statement. Providers must submit the requested information within the timeframe outlined in the request for information from HealthTeam Advantage.

Members or their authorized representative can file a grievance at any time in writing or by telephone.

- **Standard Grievances** - HealthTeam Advantage's Appeals and Grievances staff must respond within 30 calendar days of the date that the request is received by the plan, or as expeditiously as the member's health requires

- **Expedited Grievances** - Must meet the CMS criteria for an expedited grievance. HealthTeam Advantage's Appeals and Grievances staff must respond within 24 hours of the date and time that the request is received by the plan, or as expeditiously as the member's health requires

Members may send a written grievance request to:
HealthTeam Advantage
Attn: Appeals and Grievances Department
300 E. Wendover Ave., Ste. 121
Greensboro, NC 27401

Fax: 1-800-845-4104

Members make a verbal grievance request by contacting a HealthTeam Advantage Healthcare Concierge Representative at 888-965-1965.

What is a Complaint Tracking Module?

A CMS Complaint Tracking Module (CTM) case is a formal grievance submitted to the Centers for Medicare & Medicaid Services when a Medicare Advantage or Part D member reports dissatisfaction that the plan has not resolved through normal channels. Because CTMs trigger regulatory oversight and require strict response timelines, we ask that our provider partners help guide members to contact the plan directly first whenever they experience concerns or dissatisfaction. Early engagement with our Customer Service and Provider teams allows us to address issues promptly, prevent unnecessary CTM filings, and ensure members receive timely, accurate assistance. Your support helps improve member experience and maintains compliance across our network.

Quality Improvement

HealthTeam Advantage promotes quality care and service excellence for its members. The organization's Quality Management (QM) program provides the framework and structure within which the health plan pursues this commitment. The framework includes the health plan consulting with network physicians in selecting and prioritizing quality improvement projects, developing indicators, analyzing performance, identifying and proposing solutions to problems, and aiding in the communication of program activities with other providers.

The program promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality management activities based on findings. It is established at the direction of and approved by the Board of Directors, the governing body for HealthTeam Advantage.

The President is designated the authority and is responsible for the overall operation of the program. The Medical Director, the senior clinical staff member, is responsible for all clinical aspects of the Program and works closely with the Vice President of Pharmacy Operations and Quality programs to carry out those responsibilities. All senior and department leadership are responsible for implementing the Program throughout the organization. The Plan committee structure has an important role in implementing the Program and includes network providers in their membership.

The Program is designed to comply with regulatory requirements. It is evaluated and updated on an annual basis.

The overall goal of the Quality Management Program is to achieve quality care and services for members through the development, implementation, and ongoing improvement of organizational systems.

Consistent with its emphasis on quality, HealthTeam Advantage maintains the Quality Management Program with goals to:

- Promote physical and mental health for HealthTeam Advantage members;
- Promote evidence-based medicine;
- Promote healthy lifestyles, risk identification, and early intervention;
- Promote active involvement by the member in health care planning and decision-making;
- Promote and coordinate efficient and effective resource utilization;
- Facilitate timely access and availability to care and services;
- Facilitate communication regarding performance improvement initiatives;
- Promote consumer safety.

Confidentiality

All records and proceedings of the Quality Management Program and the Quality Council as well as the subcommittees, related to a member or practitioner-specific information, are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information. All member or provider information is maintained in confidential files. The health care providers hold all information in the strictest confidence. Members of the Quality Improvement Committee and the subcommittees sign a "Confidentiality Agreement" annually. This agreement requires the members to maintain the confidentiality of all information discussed during the meeting. The CEO, per applicable laws regarding confidentiality, issues Quality Management reports when required by law.

Due to the nature of routine Quality Management operations, HealthTeam Advantage has implemented policies and procedures to protect and ensure proper handling of confidential and privileged medical record information. Upon employment, all HealthTeam Advantage employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality.

Conflict of Interest

HealthTeam Advantage maintains a Conflict of Interest policy to ensure potential conflicts are avoided by staff and members of committees. This policy precludes using proprietary or confidential HealthTeam Advantage information for personal gain of the gain or others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. No person may participate in the review, evaluation, or final disposition of any case in which that person has been professionally involved in where judgment may be compromised.

Fiscal and clinical interests are separated. HealthTeam Advantage and its delegates do not specifically reward practitioners or other individuals conducting utilization reviews for issuing denials of coverage, services, or care.

There are no financial incentives for utilization management decision-makers that could encourage decisions that result in underutilization.

Quality Management Scope

The scope of the Quality Management program encompasses both clinical and non-clinical care and services conducted at HealthTeam Advantage and by its providers. Inherent in its structure is ongoing education to integrate the continuous quality management model across all HealthTeam Advantage functions and its delegated entities. Under the direction of the plan Medical Director, HealthTeam Advantage coordinates and facilitates ongoing monitoring and improvement of activities outlined in its Quality Management Program Description and Work Plan.

Health promotion and health management activities are an integral part of the Quality Management program. Particular attention is given to high-volume, high-risk areas of care, and services of the populations HealthTeam Advantage serves.

HealthTeam Advantage has integrated quality management activities into all health plan functional areas. These include, but are not limited to, the following functional areas and departments:

- Medical Health Services including Complex Care Management, Disease Management, Care Coordination, and Care Transitions;
- Operations, including member and provider services;
- Network Management;
- Compliance;
- Member Services;
- Appeals and Grievances;
- Claims;
- Delegation Oversight;
- Credentialing Oversight;
- Pharmacy;
- Utilization Management;
- Risk Adjustment

The Quality Improvement program description and evaluation are reviewed and approved not less than annually by the Quality Council.

Ultimate review and approval of the Quality Management program description, annual evaluation, and work plan, rests with the Board of Directors.

Goals and Objectives

Quality Management's goal is to improve the health status of members through high-quality, well-coordinated care;

- Deliver exceptional performance as demonstrated by internal measures and the Centers for Medicare and Medicaid Services (CMS) 5-star rating system;
- Promote the use of evidence-based medicine by the health plan and by network providers;
- Facilitate early risk identification and interventions;
- Involve members in health care planning and decision-making,
- Promote healthy lifestyles;
- Coordinate utilization of medical technology and other medical resources efficiently and effectively for member welfare;
- Facilitate effective organizational communication of performance improvement initiatives and priorities;

- Establish an environment responsive to member concerns and grievances;
- Facilitate timely access and availability to care; and
- Promote consumer safety.

Quality Management Activities

Integration is a vital component of successful quality management. Departments involved in quality management activities are integrated through coordinated referral processes and systems for quality/risk/utilization issues, care management, and member complaints/grievances. As the central area for receiving potential quality/risk management issues and coordination of Quality Management activity, the Quality department acts as a critical interface between HealthTeam Advantage departments, Centers for Medicare & Medicaid Services (CMS), and other regulatory agencies.

HealthTeam Advantage collaborates with its provider network to ensure quality initiatives and goals are met.

The Quality Management program uses a variety of mechanisms to continuously measure, evaluate, and improve the care and services provided to members. HealthTeam Advantage has adopted a uniform approach to quality and the processes for addressing quality issues. Process steps include designing, measuring, assessing, and improving processes utilizing the Plan-Do-Study-Act (PDSA) cycle to meet or exceed the minimum performance standards established by the organization.

The following activities are included in the Quality Management program and reflect important aspects of care and service:

Clinical Practice and Preventative Health Guidelines

Evidence-based guidelines are used to monitor and improve the quality of care provided by participating practitioners. HealthTeam Advantage evaluates the most current medical evidence including but not limited to, the U.S. Preventative Services Task Force, the Centers for Disease Control, and Preventative specialty organizations. HealthTeam Advantage measures population-based performance against preventative health and clinical guidelines annually, primarily through HEDIS measurement.

Disease Management

Disease Management services are available to HealthTeam Advantage members at no cost. Our Care Management department provides transitions of care, disease, and care management activities for congestive heart failure (CHF), diabetes, chronic obstructive pulmonary disease (COPD), hypertension (HTN), and major depression for plan members and beneficiaries who meet the program's eligibility criteria. Disease Management is a program of coordinated health care interventions and communications for members with conditions in which patient self-care

efforts are significant to outcomes.

The Disease Management Program Goals:

- Support the physician or practitioner/patient relationship and plan of care;
- Emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies;
- Evaluate clinical, humanistic, and economic outcomes on an ongoing basis to improve overall health.
- Enhance member self-management skills
- Reduce the intensity and frequency of disease-related symptoms
- Enhance member quality of life, satisfaction, and functional status
- Improve overall member adherence
- Facilitate appropriate health care resource utilization
- Reduce avoidable hospitalizations, emergency room visits, and associated costs related to the disease; and medical claim costs.

Providers can make referrals for Disease Management by sending a referral request by email to caremanagement@htanc.com, calling our Care Management department at 844-806-8217 option 6.

Complex Case Management

Complex Case Management is available to members identified as high risk for adverse health outcomes. The goal of Complex Case Management is to facilitate appropriate care and services for plan members who have experienced a significant health event or illness.

The Complex Case Management Program is a more intense case management approach and utilizes a multidisciplinary team of registered nurses, social workers, pharmacists, dieticians, and physicians. Evidence-based guidelines for complex case management focus on standardized assessment and screening tools, condition-specific clinical guidelines, and case management-specific assessments targeted to at-risk populations. The goal is to help members achieve optimal health outcomes in balance with available resources.

Additionally, the complex case management community-based program facilitates access to community resources through social work support to patients and caregivers across the care continuum. Members are identified through various avenues, including predictive modeling, discharge planning activities, and/or physician referrals. These services are offered to plan members at no cost, if applicable to their individual needs.

Referrals for Complex Case Management can be made via our Care Management department, at 844-806-8217 option 6 or by emailing caremanagement@htanc.com.

Medical Record Review (MRR)

The objectives of Medical Record Review activities are to:

- Evaluate compliance with medical record documentation requirements.
- Document the presence of information that conforms to accepted standards of medical practice, which includes evidence of continuity and coordination of care.
- Evaluate compliance with medical record confidentiality policies.

HealthTeam Advantage's MRR for Primary Care Providers (PCPs) is conducted per state, CMS, and quality requirements at least every three years by the Medical Management department. Overall results and opportunities for improvement are reported to the Delegation Oversight Review Committee (DORC).

Improvement action plans as recommended by the DORC, are implemented and monitored by the Medical Management department.

Member Satisfaction

Member satisfaction is assessed through annual member satisfaction surveys such as the Consumer Assessment of Health Providers and Systems (CAHPS), Health Outcomes Survey (HOS), as well as member complaint/grievance and disenrollment data. Member survey results are used to:

- Measure HealthTeam Advantage performance and identify opportunities for improvement.
- Measure the effectiveness of previously implemented improvement interventions.
- Establish benchmarks and monitor HealthTeam Advantage performance against national CAHPS performance data.
- Assess overall levels of satisfaction to determine if HealthTeam Advantage is meeting member expectations.

Action plans to address opportunities for improvement, based on member satisfaction results, are reviewed and approved by the Quality Council.

Monitoring of Performance Indicators

Ongoing monitoring of performance indicators is designed to reveal trends and improvement opportunities in targeted populations, National standard indicators, e.g. Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS) are used to continuously measure HealthTeam Advantage performance.

Results are used to identify current gaps in care of service and are integrated into quality improvement projects for HealthTeam Advantage.

Practitioner Accessibility and Availability Monitoring

Practitioner accessibility and availability monitoring are conducted on an ongoing basis to ensure that established standards for the reasonable geographic location of practitioners, number and type of practitioners, appointment availability, provision for emergency care, and after-hours service are measured. The cultural, ethnic, racial, and linguistic needs of HealthTeam Advantage's members are assessed on an ongoing basis and formally evaluated at least annually. Monitoring activities may include practitioner surveys, onsite visits, evaluation of member satisfaction, evaluation of complaints/grievances, geo-access surveys, and when applicable, monitoring of closed primary physician panels. For more information regarding access and availability monitoring, please contact your assigned Provider Concierge Representative.

Specific deficiencies are addressed with a Corrective Action Plan (CAP), and follow-up activity is conducted to reassess compliance. Practitioner accessibility and availability activities are reported to and overseen by the Quality Management Committee.

Monitoring/Improvement of Quality Indicators

The selection of objective and measurable indicators for programs and interventions impacting the effectiveness of care and services are based on industry-wide specifications used to assess the quality of care of functional status, access, satisfaction, and outcomes (e.g. HEDIS, CAHPS, HOS).

Data is retrieved from the HealthTeam Advantage data tables, a central repository of all transaction systems, including but not limited to member demographics, claims and encounters, pharmacy, and laboratory data. Supplemental data sources, such as medical records, case management, and member-reported health assessment data, are used to support reporting, validation, and analyses. Chronic Care Improvement Programs (CCIPs) specifically address the unique characteristics and special needs of the HealthTeam Advantage population, hence they are stratified by plan type, age, disease categories, and risk status.

Care and services are evaluated in a variety of settings including institutional and ambulatory. The Plan also evaluates the coordination among contracted providers and outside agencies. Inherent in the structure is ongoing, continuous education to integrate the quality management process model across all HealthTeam Advantage functions and delegated entities.

Outcomes are assessed by the annual HEDIS report, comprised of a comprehensive description and assessment of the HealthTeam Advantage transaction systems and internal audit processes (Roadmap), data integration and rate generation, collection and review of medical records, management and coordination of the HEDIS audit by outside certified audit agency, and a final report to CMS. The project involves an organization-wide effort to ensure data accuracy and completeness.

HOS and CAHPS results are reviewed to assess member health status and satisfaction with plan

services and care received.

CMS issues the annual CAHPS and HOS baseline and associated reports. An analysis of HealthTeam Advantage's results is presented to the Quality Council as an attachment to the annual Quality Program Evaluation. The analysis includes recommendations for process improvements and quality initiatives.

HealthTeam Advantage collects, analyzes, and reports Part C reporting data elements to CMS as defined by regulatory and technical specification outlines from CMS. The data are collected both internally and externally from our delegated entities.

Patient Safety

HealthTeam Advantage supports the prevention and elimination of healthcare errors through its commitment to the practice of Evidence-Based Medicine. This is accomplished through a variety of mechanisms, including but not limited to, processes to report identified adverse events, Medication Therapy Management Program (MTM), and potential quality of care referrals. Also, HealthTeam Advantage provides education to members to promote patient awareness, encourage healthcare advocacy, and facilitate decision-making through the HealthTeam Advantage newsletter and other program-specific materials.

Never Events Policy

HealthTeam Advantage has determined that if a healthcare service is deemed a "never event" or a "hospital-acquired condition" as defined by CMS, neither HealthTeam Advantage nor the member will be responsible for payments for said services. Healthcare facilities and providers are prohibited from collecting and/or billing for co-payments, coinsurance, deductible charges, or balance billing HealthTeam Advantage or its members for events that are designated as ineligible for payment.

Examples of additional charges directly resulting from the occurrence of such a "never event" include:

- The event results in an increased length of stay, level of care, or significant intervention.
- An additional procedure is required to correct an adverse event that occurred in the previous procedure or provision of healthcare service.
- An unintended procedure is performed.
- Readmission is required because of an adverse event that occurred in the same facility.
- These guidelines do not apply to the entire episode of care, but only the care made necessary by the serious adverse event.

According to the above guidelines, a healthcare facility or provider will not seek payment for costs directly resulting from the occurrence of the following surgical events:

- Surgery was performed on the wrong body part.
- Surgery was performed on the wrong patient.
- Wrong surgical procedure on a patient.
- Retention of a foreign object in a patient after surgery or other procedure.
- Intraoperative or immediate postoperative death in an otherwise healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologist patient safety initiative).
- Surgical Site infections following orthopedic, CABG, and bariatric procedures

Potential Quality Issues

HealthTeam Advantage maintains a system of trended quality issues identified over time, using the Quality Management process.

Potential quality issues may be referred to from a variety of internal and external sources. All quality issues identified by HealthTeam Advantage staff or providers will be investigated and assigned a quality determination through the reportable events policy and procedures.
The Quality Department's clinical staff conducts the preliminary review and investigation, with a subsequent review by a physician and/or referral for physician peer review. Cases are referred to the Quality Council if further review is needed.

Over-Utilization or Under-Utilization of Services

HealthTeam Advantage has established a methodology for monitoring the over- and under-utilization of services. Using data submitted by the provider organizations, HealthTeam Advantage compares the utilization of several key indicators to specific performance standards. Key indicators may include, but are not limited to, Bed Days/1000; Average Length of Stay (LOS) for Acute, Skilled Nursing, and Behavioral Health care; ER Visits/1000, and member appeals.

CMS Star Rating

HealthTeam Advantage has a comprehensive CMS Star program that sets a target of 4 star with a stretch goal of 5 every year. Strategies to achieve this goal include, but are not limited to:

- Obtain executive leadership buy-in and promotion of quality
- Educate all staff members on their impact on the CMS star rating for HealthTeam Advantage
- Integrate quality initiatives across the organization
- Promote a culture that is integrated/cooperative, nimble, flexible, and accountable
- Data Collection and identification of opportunities for improvement (HEDIS, CAHPS, Provider Reporting)
- Develop unique initiatives aimed at both providers and members

Quality Management Outcome and Evaluation

The Quality Management Program description and the Work Plan govern the program structure and activities for one year. No less than annually, the Quality Department in cooperation with key departments throughout HealthTeam Advantage, completes a formal evaluation to include:

- Completed and ongoing activities that address the quality and safety of clinical care and services.
- Trending of performance measures related to the quality and safety of clinical care and service.
- Analysis of results, including barrier analysis and opportunities for improvement.
- Evaluation of overall effectiveness and progress towards network-wide safe clinical practices.

The Board of Directors approves the Quality Improvement Program annually.

Risk Adjustment

CMS first implemented the Hierarchical Condition Category (HCC) risk adjustment model in 2004 as the methodology to risk adjust Medicare capitation payments to private health insurance companies offering Medicare Advantage plans.

There are two different models for Hierarchical Condition Category (HCC) risk adjustments. The U.S. Department of Health and Human Services (HHS) oversees the HHS-HCC risk adjustment model 2020, which covers commercial payers of all ages and determines risk payments for the current year. The Centers for Medicare and Medicaid Services (CMS) uses the CMS-HCC model for the Medicare Advantage program and those who qualify for Medicare or patients 65 and older, calculating risk payments for the next year.

As of 2020, there were 86 HCC codes, arranged into 19 categories. Effective in 2026 there are now 115 HCCs. Due to the changes, there will be a combination of each model until CY 2026, whereby 100% of the HCCs will be based on the 2026 HCC model. Each HCC code represents a group of one or more ICD-10-CM codes. Additionally, one ICD-10-CM code can also be found within more than one HCC. All diagnosis codes must be coded to the highest level of specificity and be supportive of the provider's documentation.

HCC Coding

Patients are assigned risk adjustment scores based on the diagnosis codes submitted by a medical provider and when done during a face-to-face encounter with the member. Each medical claim submitted to the plan contains the diagnosis codes which substantiate the service that was rendered to the member and is based on the provider's medical record documentation. It is through the provider's diagnosis coding that the plan and CMS can fully understand how healthy or sick our members may be.

At least yearly, each of HTA's members who have one or more chronic conditions is required to be re-evaluated. For instance, members who have had an amputation or other colostomy in the year prior, need the condition re-evaluated. Amputations are a permanent chronic condition while a colostomy may be temporary. Re-evaluating, at least annually, the member's chronic conditions ensures that all permanent chronic conditions are being recaptured and are under active medical treatment or documented as a history of the condition. One of the most effective ways to re-evaluate a member's chronic condition(s) is by performing an annual wellness visit and/or physical exam. This type of exam not only helps the Risk Adjustment team with recapture of all the current conditions, but it also assists the Quality Improvement team with their initiatives and documenting all current and relevant medical conditions.

HTA requires all providers to accurately assign the most specific diagnosis code which reflects HTA's member's condition. Providers must also ensure their documentation supports the diagnosis code billed to the plan.

Diagnosis Coding Tips

Providers must ensure that the diagnosis codes submitted to the plan are coded to the highest specificity and according to the ICD-10-CM Official Coding Guidelines. ICD-10-CM codes are reviewed, changed, or deleted annually and become effective October 1, 20xx.

Examples of Acceptable vs. Unacceptable Coding:

- A 65-year-old female with major depressive disorder, single episode, moderate. **(Acceptable)**
- Depressed 65-year-old woman. **(Not acceptable)**
- A 68-year-old male with morbid obesity, BMI 42. **(Acceptable)**
- A 68-year-old overweight male. **(Not acceptable)**

While there may be other unspecified diagnosis codes that fit a particular condition, coding to the most specific condition the member has, is required.

Social Determinants of Health (SDOH)

SDOH is a required component of a medical record. It allows the physician, their office, and HTA to assist a member when an SDOH condition is identified. SDOH conditions are documented in the medical record as a diagnosis code. The importance of an SDOH condition cannot be understated. Once a SDOH condition has been identified, it will enable your office to provide better health outcomes for the member.

Example:

Member comes into the office and is questioned on one of the SDOH questions and has responded positively to a financial crisis or housing concern, this could greatly impact treatment.

Member makes comments about the financial situation they are in, specifically, they are most likely not going to afford a more costly medication. This also would affect their dietary choices prescribed. A positive health outcome is not likely because the member cannot actively follow their recommended treatment.

If your office is unsure of the resources available, please have the member contact our Healthcare Concierge department.

MEAT

MEAT is an acronym used by many medical professionals to ensure the documentation supports the diagnosis code billed.

Monitoring, signs, symptoms, disease progression, disease regression
Evaluate test results, medication effectiveness, and response to treatment
Assess/Address ordering tests, discussion, review records, counseling
Treatment-medication, therapies, and other modalities

Risk Adjustment Data Validation (RADV) Audits

A Risk Adjustment Data Validation (RADV) audit is an industry-wide contract audit of diagnosis codes the plan has billed to CMS and subsequently received payment. The goal of this audit is to determine the plans' overall error rate submitted diagnosis codes. If CMS or the Contracted Reviewer determines the codes submitted by the plan were not accurate, the plan may be required to pay CMS back for the monies paid for the inaccurate diagnosis codes.

Upon selection of a RADV, CMS will select a set number of enrollees with specific HCCs to be audited. The audit will evaluate the diagnosis codes/HCCs submitted to CMS. Contracted CMS coders will determine if the provider's documentation supports the HCC code. HTA relies on the accuracy of all providers' coding and documentation. If an HCC is not found during the RADV, CMS will impose an error rate. Specifically, "An annual payment error amount will be calculated for each sampled enrollee based on the number of months the person was enrolled in the selected MA contract (and was not in ESRD or hospice status) during the payment year." Accurate provider documentation inherently is the key to a successful RADV audit.

If HTA is selected for a RADV, per Federal regulations, MA organizations and their providers and practitioners are required to submit medical records for the validation of risk adjustment data (42 CFR §422.310). As a network provider, you are required to submit these records without charging the plan a fee.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf

Prospective and Retrospective Programs

HTA is contracted with vendors to perform in-home, in-office assessments, and retrospective chart reviews.

In-Home Assessments

This is a program that sends a practitioner out to a member's house or via a video/audio interface to perform a comprehensive assessment of the member. The practitioner will perform a physical examination, review of systems, past medical history, review of medications, diagnoses, patient education, perform agreed-upon testing such as A1C, fecal tests, and diabetic retinopathy testing, and address closing any other gaps.

During the visit, if an urgent condition or new diagnosis is found, the practitioner will contact the patient's PCP and inform them of the condition. Additionally, the plan is also made aware of the member's condition for the clinical team to be on point to assist the member if needed.

After each visit, a summary report of the visit is mailed to the member's PCP on file with the plan. HTA requests that the provider or other clinical staff review this summary report for accuracy, as well as for the management of your patient. If you determine there is an error with the report, such as a wrong diagnosis code that does not apply to the member, please contact your provider concierge so we can investigate it and make any necessary changes to the record.

In-Office Assessments

The In-Office Assessment program is an incentive-based provider program. The goal of the program is to reassess chronic conditions that were confirmed the prior year but have not been captured in the current year for risk adjustment. The program also contains a quality section addressing quality measures not met in the current year.

The program requires the provider to use the assessment form at the point of care as a guide, which directs the provider to assess and document in the medical record the appropriate and current diagnosis codes, screening exams, and recommended treatment for each condition and/or quality gap in care. The form must also be filled out and sent back to the vendor along with the chart notes that correlate the HCC codes needing to be reassessed and the quality gaps addressed.

Providers interested in this program are welcome to contact our provider concierge team to let them know about your interest in the program.

Retrospective Chart Review Progam

The retrospective chart program is a program designed to determine if the diagnosis codes submitted to the plan were accurate. If the diagnosis codes were found not to be supported by the documentation, the plan will remove them from CMS's systems. *(Please note, the removal does not impact the claim payment issued by the plan to you for services rendered.)* Similarly, if additional diagnosis codes were identified during the chart review that can be captured based on the medical record documentation, the plan will submit those additional diagnosis codes to CMS.

To perform this record review, your office may be contacted by one of our risk adjustment team members for medical records or by our vendor, CIOX. Please process these medical record requests as expeditiously as possible. For more information on the medical records process, please see the "medical records" section.

Provider Engagement and Education Activities

As part of the overall compliance and management of the Risk Adjustment services at HTA, provider education and engagement with the provider office/clinical staff/provider is critical to ensuring the member's conditions are being treated appropriately and documented with the best supportive and most specific diagnosis code.

Our team writes articles about coding trends and coding documentation pitfalls to avoid in the monthly provider newsletter. We also participate in the provider roundtables that our provider concierge team offers. There, you will find additional information about diagnostic coding trends seen as well as any other coding rejections we receive from CMS based on the claims data sent to them.

To maintain the highest level of care for our members, we welcome any suggestions you have regarding the types of engagement, diagnosis coding trends, or other patterns you would like to see

We value all our providers' input. Our team would love the opportunity to work with your clinic/practice/organization to determine how well the clinic/practice/organization/provider has been reassessing chronic conditions and what improvements might be needed, which will help further support the diagnosis codes billed by your providers. If your practice is interested in this opportunity, please reach out to your Provider Concierge or email RiskAdjustment@htanc.com.

Medical Records

HTA follows state and federal laws regarding the retention of records. The North Carolina State Medical Record Retention Policy, states the "Adult Clinical Medical Records: includes admission records, physical examination, and laboratory reports, medical treatment notes, discharge plans, and summaries, patient transfer certifications, radiology, and diagnostic imaging records, medication administration records, living wills, authorizations to release patient information, communicable disease reports, consent to test forms and other related records, *must be retained until the last encounter plus 11 years*." For more time frames on other medical record state and federal retention policies, please refer to the website at the end of this section and to HIPPA and CMS retention guidelines.

For all Medical Record requests from either the Risk Adjustment, Care Management, Quality Department, Claims Department, Appeals and Grievance Department, CIOX, or another vendor on behalf of HTA, the records should include at least one of the following types of medical record documentation listed below:

Medical Record Documentation Required **IF** Available:

• Face Sheet (Include documentation for name changes and DOB discrepancies) • Progress Notes • History and Physical • Discharge Summary • Consult/Specialist Notes or Letters • Demographics Sheets (Include documentation for name changes and DOB discrepancies) • Operative Notes • Lab Results/Pathology Reports • Emergency Department Records	• Lab Notes • Diagnostic Testing Reports • Anesthesia Reports • Coding Summary (if not on face Sheet) • Physical, Speech, and/or Occupational Therapists Reports. • Signature Log (complete and return if progress notes contain handwritten signatures or credentials of the provider are not contained in patient information being sent)

Each medical record received is used for a variety of reasons such as retrospective record reviews, claims review requests, appeals, and grievances, quality record reviews, etc. Access to records is your contractual obligation and should be granted to HTA, or its representatives, without a fee when possible. Providers should have procedures in place to permit the timely access and submission of medical records to HTA upon request.

Advanced Directives

Living Will Declaration and Advance Directives

The Omni Budget Reconciliation Act (OBRA) of 1990 included a substantive new law that has come to be known as the Patient Self-Determination Act and which largely became effective on December 1, 1991.

The Patient Self-Determination Act applies to hospitals, nursing facilities, and providers of home health care or personal care services, hospice programs, and Medicare Advantage health plans (HealthTeam Advantage) that receive Medicare or Medicaid funds. The primary purpose of the Act is to ensure that members of HealthTeam Advantage are made aware of advance directives and are allowed to execute them if they so desire. This Act also prevents discrimination in care if the member chooses not to execute advance directives.

What is a Health Care Advance Directive?

A health care advance directive is the primary legal tool for any health care decision made when you cannot speak for yourself. "Health Care Advance Directive" is the general term for any written statement you make while competent concerning your future health care wishes. Formal advance directives include the living will and the health care power of attorney.

What Does CMS Require of HealthTeam Advantage?

HealthTeam Advantage is required to include a description of our written policies on advance directives to our members including an explanation of the following:

- HealthTeam Advantage cannot refuse care or otherwise discriminate against an individual based on whether the individual has executed an advance directive;
- Each member has the right to file a complaint if the member believes HealthTeam Advantage is noncompliant with advance directive requirements, as well as the information on where to file the complaint;
- When applicable, HealthTeam Advantage requires that all providers document in a prominent part of the individual's current medical record whether the individual has executed an advance directive;
- HealthTeam Advantage is required to comply with North Carolina State law. Visit www.caringinfo.org for information regarding forms and terminology. You may also share this website with your HealthTeam Advantage members;
- HealthTeam Advantage must provide community education regarding advance directives.

Delegated Activities

Medicare Advantage Organizations commonly contract with delegated entities to perform certain functions that otherwise would be the responsibility of the organization to perform, including management and provision of services.

The Medicare Advantage Organization, however, remains ultimately responsible for all services provided and otherwise fulfills all terms and conditions of its contract with CMS regardless of any relationships that the organization may have with other entities.

Medicare Advantage Organizations must oversee and be accountable for any functions or responsibilities that are delegated to other entities. It is the sole responsibility of the Medicare Advantage Organization to ensure that the function is performed per all applicable standards.

HealthTeam Advantage has the sole discretion to allow the delegation of activities to providers or other entities. Delegated entities may not modify the delegated activities or the obligation to perform the delegated activities without prior written consent from HealthTeam Advantage.

Delegated entities are responsible for the performance of all delegated activities, including reporting requirements, per all applicable laws, this manual, and other administrative policies and procedures of HealthTeam Advantage as may be amended from time to time. HealthTeam Advantage will provide delegated entities with HealthTeam Advantage's standards and requirements applicable to the delegated activities and will notify delegated entities of any substantive changes to these standards and requirements.

Delegated entities may utilize their policies and procedures for the delegated activities, provided that and only to the extent such policies and procedures are consistent with HealthTeam Advantage's delegation policies. If the delegated entity's policies and procedures are inconsistent with HealthTeam Advantage's delegation policies, HealthTeam Advantage's delegation policies will apply.

The contract between HealthTeam Advantage and the delegated entity specifies the activities that have been delegated if any, and reporting responsibilities. Delegated entities should refer to their contract with HealthTeam Advantage for additional information.

Delegation Determinations and Monitoring/Auditing

Before the delegation of any activity, HealthTeam Advantage evaluates the entity's ability to perform the delegated activity and documents that it has approved the entity's policies and procedures concerning the delegated activity. HealthTeam Advantage also verifies that the entity has devoted sufficient resources and appropriately qualified staff to perform the function.

HealthTeam Advantage monitors the performance of the delegated entity on an ongoing basis and formally reviews the performance of the entity at least annually. HealthTeam Advantage has established a multi-disciplinary Delegation Oversight Review Committee that is ultimately responsible for maintaining a comprehensive oversight program for the routine monitoring of delegated activities performed on behalf of HealthTeam Advantage by delegated entities.

HealthTeam Advantage has written procedures for monitoring and review of delegated activities. HealthTeam Advantage uses Delegation Oversight Audit tools to conduct pre-delegation due diligence as well as focused and annual audits of delegated entities.

The Delegation Oversight Audit includes, but is not limited to, a review of all applicable policies and procedures and the evidence demonstrating the implementation of the processes, a file review as applicable, a review of applicable committee minutes, and any additional documentation required to demonstrate the performance of the delegated activities.

A HealthTeam Advantage representative works collaboratively with the delegated entity to schedule and perform the audit. HealthTeam Advantage may also, at its discretion, perform unscheduled audits as it deems necessary. The results of the audit and any requirements for corrective action will be returned to the delegated entity within 30 days of the date of HealthTeam Advantage's recommendation/determination. HealthTeam Advantage will also send a confirmation letter to the delegated entity designating the functions that have been delegated.

Depending on the results of a pre-delegation review or ongoing auditing and monitoring, HealthTeam Advantage will assign one of the following delegation statuses to the entity:

- Full Delegation: The delegated entity is authorized to perform delegated activities with ongoing monitoring and, at a minimum, annual oversight audits performed by HealthTeam Advantage.
- Conditional Delegation with a Corrective Action Plan (CAP): If the delegated entity fails to meet the standards required to maintain or be granted "Full Delegation" status, a CAP is required with Conditional Delegation status which may include more frequent and/or focused audits. All CAP activities and submissions are reviewed by the Delegation Oversight Review Committee for the determination of delegated status.

Revocation and Resumption of Delegated Activities

Per CMS regulations, HealthTeam Advantage or CMS may revoke delegated activities and reporting requirements, or specify other remedies, in instances where CMS or HealthTeam Advantage determines that a delegated entity has not performed satisfactorily.

Delegated entities should refer to their contract with HealthTeam Advantage for specific details regarding how deficiencies and de-delegation will be handled.

Should an entity request to be considered for the re-delegation of activities, the Delegation

Oversight Review Committee will review any request for re-delegation.

Compliance Requirements

To meet CMS requirements, all delegated entities are also required to complete an annual Compliance Attestation Process. For more information about HealthTeam Advantage's commitment to compliance, integrity, and ethical values, visit our website at https://htanc.com/compliance-integrity/.

healthteam advantage℠

We're Here for You!

Online

Visit **htanc.com/providers.**

By Phone

Your Provider Concierge
844-806-8217, Option 2
8 a.m.–5 p.m.

By Email

ProviderConcierge@htanc.com

Connect with us

HealthTeamAdvantageHTA *@healthteamadvantage* *@healthteamadvantage*